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On Being a New Broom

Whenever a new appointment is made, while everyone wishes the new incumbent the best of luck, sometimes there is a tendency to adapt a "wait and see" attitude. Some may even use the time-worn phrase, applied alike to superintendents of nurses and ward aides, to a clergyman or the janitor or to the editor and business manager of *The Canadian Nurse*, "A new broom sweeps clean". Being the new broom, in this instance, it seemed pertinent to analyze the situation and see what inferences can be drawn from the implied similarity.

In the first place, this inanimate object, this broom, is to sweep clean — to do a thorough job. In order to do that there must be a period of orientation, of learning all the manifold details of this very important piece of work. During this learning process, there may be blunders through inexperience. So far as possible, these will be guarded against; for such as may occur, indulgence is begged. Mark well the order of the two words— "sweep clean". There is no thought of a possible interpretation which might come from reversing the order and making a "clean sweep". The *Journal* is no more static than any other element in life, so some changes will gradually evolve but the former editors have built on a strong foundation and certainly, no sudden revolution in policy or practice will be instituted.

The second and equally important inference concerns the broom itself. Who is responsible for guiding its activities? Happily, there is an Editorial Board to whom the new and untried editor may turn for advice and assistance. This is the policy-forming body the members of which receive support and direction from the Executive of the Canadian Nurses Association, an Executive that is representative of every province across Canada. Since the Canadian Nurses Association owns and publishes the *Journal*, each individual member of that Association has a certain degree of responsibilty.

Though this fact has been pointed out frequently many nurses are not aware of their responsibilities to and for the *Journal*. How can they assist the new editor to do a thoroughly good job? First, by being interested themselves and interesting others in the magazine. Second, by preparing pertinent material in the form of readable articles or by keeping the editor informed of possible sources; a healthy circulation and a sound renewal rate are impossible without a content of worthwhile material which genuinely appeals to the reader. While many people are averse to expressing their opinions in writing, comments good and bad are at least a sign that an impression has been formed. By making suggestions and recommendations to the editor, the types of articles included in the *Journal* can be best adapted to the needs of the nurses. Most important, use the *Journal* in as many situations as possible in provincial, district, chapter, and alumnae meetings, in conferences, and as reference reading. Perhaps by thus working together we shall discover that we and the *Journal* have grown to a fuller stature.

—M.E.K.

An Expression of Appreciation

Nurses across Canada unite in a tribute to the editor and business manager of our *Journal* who resigned from her position at the end of June. It would seem unnecessary and inappropriate to eulogize Miss Johns, for her work speaks for her, as evidenced by the public and professional recognition which has been accorded her at home and abroad. During the past eleven years, Miss Johns has made a contribution to nursing which it is impossible to measure. Her broad interpretation of the ideals and practice of nursing, as reflected in the pages of *The Canadian Nurse*, has had a profound influence upon the lives of nurses, and upon the spirit and progress of nursing.

ETHEL JOHNS

At a recent meeting, the Executive Committee of the Canadian Nurses Association recorded sincere appreciation of Miss Johns and her work in the following resolution:

> Whereas it has been announced that Miss Ethel Johns will shortly be relinquishing her present duties after long and distinguished service as editor and business manager of *The Canadian Nurse*, and, whereas, under her efficient direction, the *Journal* has reached its present high standard, be it resolved that this Association record its deep appreciation of this and other outstanding contributions to nursing in Canada, and express its pride in her achievements in international nursing.

The Canadian Nurses Association extends to Miss Johns its very best wishes

for a future which will provide the time and opportunity for her to indulge in activities and interests which had to be postponed during her busy years as editor and business manager of *The Canadian Nurse*.

Royal Canadian Naval Well Baby Health Service

NURSING SISTER PHYLLIS M. REAY, R. C. N.

"The Navy certainly gets them young" has been a popular saying around Halifax for the past year. The reason for this is that over a year ago now one of the most unique forms of preventive national health service — a well-baby health clinic was organized. Its organization was carried through, in conjunction with the Halifax Branch of the Medical Society of Nova Scotia and the Dalhousie Health Clinic, by three naval officers. They are Surgeon Captain D. W. Johnstone, R.C.N.V.R., Command Medical Officer, Canadian Northwest Atlantic, Surgeon Lieutenant Commander H. L. Bacal, R.C.N.V.R. and Surgeon Lieutenant Commander Alan Ross, R.C.N.V.R., the latter two, graduates of McGill University, Montreal, and in civil life well-known baby specialists.

At the clinics, held twice weekly at the Royal Canadian Naval Hospital, H.M.C.S. "Stadacona", pre-school age children of naval ratings are given medical examinations and immunized against diphtheria, whooping cough and small pox; mothers are given an opportunity to discuss feeding, behaviour, and problems in child care. Volunteer helpers, drawn from among the wives of naval officers and other groups, assist at each clinic, and on days when there is no clinic the Nursing Sister working in co-operation with the local social agencies visits the homes of the tiny members, helping the mothers with the care of their babies, their social troubles,and educating them in the application of modern public health and preventive medicine.

As the name implies, it is a service for well babies only, with no facilities available for the care of the sick child, but advice is given regarding medical care. The clinic is a boon to war-swollen Halifax, for it assists the local doctors in their continuous struggle to reduce disease and prevent epidemics in this overcrowded city. It is a great "morale booster" for the daddies, improves the mothers' understanding of growing children, and is a safeguard for the local population from infectious diseases through immunization and health supervision of the children in a congested transient population.

The following excerpts from a mother's baby clinic diary should help to show the "inside story" of this wonderful service:

March 16, 1943: Heard about this new service being given free to all children of naval ratings so decided to take Sandra and Bobby. We arrived at the Naval Hospital at 2.30 and the guard at the gate showed us where to go. The clinic is so bright and clean and everyone seemed so cheerful. I gave the child-

ren's past history to a volunteer at the desk as I went in, while another cheery volunteer worker in a blue smock undressed the children and weighed them. We were then shown into the doctor's cubicle in which Doctor Bacal (all the children seemed to call him "Uncle Harry") examined Bobby and Sandra, and gave Bobby his first inoculation against diphtheria. He says Sandra is too tiny yet to start hers. After filling out the children's history sheets the doctor sent us out to see Nursing Sister Ambery. She gave Bobby a cookie, and gave me two very helpful booklets put out by the Welfare Council, and also samples of cod-liver oil which the children must take each day. She was very kind and such a big help to me. I'm sure Sandra and Bobby will be the finest children in the world if I follow her good advice.

March 30, 1943: Nursing Sister Ambery called in to visit us this morning. We were so glad to see her. She thinks perhaps the children are not getting enough fresh air. I must try to get them out more often. We had tea together and I was so glad to get some advice on Bobby's temper tantrums — apparently they can be controlled!

A "Wren-to-be" passes inspection

April 6, 1943: Took the children back. Bobby had his second diphtheria inoculation which he didn't seem to mind at all, for "Uncle Harry" kept him talking and laughing the whole time. Sandra's diet has been increased now and she is to go back in three weeks to be vaccinated. Bobby got another cookie — he's going to look for one every visit now! Last Friday we heard a broadcast over C.H.N.S., telling all about the organization of the clinic. There were also some marvellous pictures and accounts of the clinic in the Halifax Herald and the Montreal Daily Star, and on Saturday there were some more pictures and accounts in the other local papers. I hear they were in most papers across Canada — hope our relatives out west see them!

April 15, 1943: Was listening to Claire Wallace on the radio to-day, and she and Jaff discussed the clinic. I was so thrilled and surprised to hear it. I never realized this health service could have such far-reaching benefits.

May, 4, 1943: Sandra was vaccinated last week and Bobby's diphtheria inoculations were completed. Thank goodness that's done. I feel so much safer about the children. Took Sandra in to have her vaccination read to-day. Two city nurses were visiting the clinic when we were there and they seemed so pleased with all the healthy looking children but mine are really the clinic's prize babies I think.

June 8, 1943: Sandra started her diphtheria inoculations to-day and Bobby started his whooping-cough. Bobby cried when the second needle went in him; he didn't like being poked in *both* arms! But he got the reliable cookie to cheer him up and Sandra got one too, so they were both happy.

June 29, 1943: Such a fine day.

There were crowds at the clinic but everything runs so smoothly we only had to wait a few minutes. One more inoculation for Sandra and we shall be finished with the diphtheria.

July 17, 1943: This wasn't our regular day at the clinic but Tuesday being Bobby's birthday the nurse told me to come in to-day. I'm so glad we did — for there were important visitors at the clinic — Mrs. Kendall, the Lieutenant Governor's wife, and Surgeon Captain Johnstone, one of the organizers of the clinic, were there. The naval photographer took some pictures — I'm anxious to see them.

August 10, 1943: Bobby's inoculations were completed today, so we don't have to go back to the clinic till the autumn. The children will miss it. Bobby can say quite a few words and amongst them is "Uncle Harry"!

November 9, 1943: It was great being back again. Some of the babies seem to have grown so much during the summer. The children had their check-up and are doing very well. Nursing Sister Ambery has left and Nursing Sister Reay has taken her place in the clinic. Saw a copy of an article by Jean Logan in the Ottawa Citizen. She had visited the clinic a short while ago during her tour of service establishments on Canada's east coast.

December 21, 1943: What a grand surprise we got when we went back to-day! There was the prettiest Chirstmas tree in the clinic, lit up and looking so gay. It is the first one Sandra has seen and I had a hard time getting her away from it. The naval photographer took pictures of all the mothers and babies around the Christmas Tree and Nursing Sister Reay is going to order some copies for me to send to Daddy!

February 5, 1944: Nursing Sister Reay visited us to-day as I was a little bit worried about Bobby. However, she advised us what to do, and I'm to see our doctor tomorrow if he's no better.

In the Naval Reserve

She showed me an article in the Halifax Chronicle to-day headed "Baby Service gets praise". It was quoting the praise given the clinic by Dr. Morton, Commissioner for Public Health and Welfare. I hear there's to be a monster birthday party in March.

March 17, 1944: What a party it was yesterday! I never dreamed there were so many children in Halifax but according to reports in the papers there were over five hundred people at the party! The Admiral cut the huge birthday cake with a sword and everyone had a piece, and we were served ice-cream and cookies too. There was a programme of acts and cartoons, put on by the Special Services, and the naval photographer took all kinds of pictures. The Lieutenant Governor and his wife, Mrs. Kendall, were there, and Surgeon Captain Johnstone and Surgeon Liteutenant Commander Bacal who each gave a short talk on the wonderful work being done by the clinic. I expect it will be a Dominion-wide health service before very long.

March 27, 1944: Heard Syd Ken-

nedy over the C.B.C. Broadcast "Canadian Round-up" tonight and he told all about the birthday party. He had been there himself and really gave a marvellous description of it. Took the children to the clinic for the last time to-day before we move out to Victoria. They were given a thorough check-up and Dr. Bacal told me they are typical healthy clinic babies. Nursing Sister Reay gave me their immunization cards showing they have been completely immunized and if ever we're back in Halifax again I'll certainly return to the clinic. I'm going to miss it so much and so will Sandra and Bobby. I do hope they start a clinic very soon at Naden, the naval base in Victoria.

Since its birth over a year ago, there has been an attendance of over 1600 children at the clinic, and more than 700 home visits have been made by the Nursing Sister. A clinic was started in Newfoundland last year, and according to reports it is doing a fine job. We are convinced that these clinics serve as a pattern and a challenge for other overcrowded cities in the Dominion, and the plan will no doubt find an important place in post-war reconstruction. In the words of Mrs. H. E. Kendall, wife of the Lieutenant Governor of Nova Scotia, "Making the world safe for democracy is not enough; we must make the world safe for babies, and the place for us to begin is Canada".

Routine – but "Stat"

Sister Margaret Mooney, R.H.

The doctor's routine order on admission of a patient to hospital ordinarily is white cell count, red cell count, haemoglobin estimation and sedimentation rate, or, as it is stated on the requisition that comes to the laboratory, a "C.B.C. and S.R." usually marked "*Stat*". The dire meaning of that word "Stat!", the very sound of which makes a technician shudder implies that "this examination is to be done immediately — if not sooner than that!" So, as "*stat*" as possible, the technician arrives at the patient's bedside and invariably is asked one of two questions — or both. "What are you taking my blood for?"—or (pathetically from the woman patient) "I haven't got very much blood left, have I?" The new, very new, technician will sweetly explain that as there are normally about six quarts of blood in the body, the patient must have at least three quarts left even though she does feel very anaemic. After the first hundred times or so, the technician just smiles patiently and agrees!

As for the first question: "What are you taking my blood for?" that is exactly what the doctor (and indirectly the technician) is interested in, too. When one considers some of the functions of the blood, such as carrying oxygen from the lungs to the tissues, carrying food material, hormones and internal secretions to the tissues and waste products to the organs of excretion, aiding in the maintenance of normal temperature, internal fluid pressure, and vascular integrity after trauma, as well as a defence mechanism against infection, it will be readily understood that a pathological condition affecting any part of the body, may have an effect on the circulating blood. This is ascer-

tained by clinical examination and may be of inestimable value to the doctor in making his diagnosis. As numerous books have been written on this subject, you will realize how inadequate a short paper must be. We will therefore briefly discuss the principles of these examinations, some of the reasons for doing them, and mention some of the diseases in which they are of diagnostic value to the physician.

For either a red or white cell count, the principle is the same. Using a special glass pipette, the blood is drawn in and diluted, 1 in 20 for counting leukocytes and 1 in 200 for counting red cells. After thorough shaking to obtain even distribution of cells, the solution is poured on a glass chamber. The cells settle to the bottom of this chamber, which is ruled in a series of minutely accurate squares. For the leukocyte count the squares are 0.1 mm. square and 0.1 mm. deep making a cubic content of 0.1 cu. mm. The number of leukocytes in four such areas are counted under the miscroscope. The number is multiplied by 2.5 to determine the number of cells in 1 cu. mm. and by 20 to allow for the dilution factor. The counting of red cells is the same, the computation differing only in the size of the squares on the counting chamber and the diluting factor. The average normal counts are from 4,500,000 to 5,000,000 red cells and from 5,000 to 10,000 leukocytes per 1 cu. mm. of blood. Although simple in principle, accurate counting of blood corpuscles involves a technique which is acquired only after considerable practice and, for the instructor, much patience.

Haemoglobin is an iron-bearing protein having a great affinity for oxygen. Normally it is confined to the red corpuscles and occurs in the circulating blood in two forms: oxyhaemoglobin — chiefly in the arterial blood — and reduced haemoglobin or, more accurately, haemoglobin, in the venous blood. There are numerous methods of estimating the haemoglobin content of the blood. One of the colorimetric methods is commonly used in clinical work. It depends on the conversion of haemoglobin into acid hematin with dilute hydrochloric acid and matching this brownish-yellow colour with a standard. All colorimetric work is subject to error due to inaccuracies and deterioration of instruments and the reading of estimations by different individuals. The photoelectric cell methods do away with the latter source of error, but the former must always be taken into consideration. The custom of recording haemoglobin in terms of percentage of an indefinite normal has led to much confusion. This could be avoided if records were made in terms of the actual number of grams of haemoglobin present. The average normal is 16 gm. per 100 cc. of blood.

A sedimentation rate is the velocity of settling of red cells per unit of time. The blood is a suspension of cells in a viscid fluid, the plasma. The constant movement of the fluid keeps the cells evenly distributed. When the circulation stops, the cells commence to settle. This is soon circumvented by the clotting process. If, however, an anticoagulant is added to shed blood, the sedimentation continues until an upper layer of clear plasma becomes separated from the cells which have descended through the fluid. It has been shown that the rate at which this sedimentation of red cells occurs varies in disease and under certain conditions of health. There is no known explanation for this phenomenon. There are several methods used to determine it, differing mainly in the anticoagulant added and the length and bore of the tube used in the actual setup. The average maximum normal rate is taken as a drop of 10 mm. in one hour, although even in health this varies within moderately wide limits. Therefore, a sedimentation rate of from 15 to 30 mm. should be regarded as slight-

ly increased; from 30 to 50 mm. as moderately increased and over 50 mm. as a severe increase.

Now, to return to the patient's query: "Why are you taking my blood?" Alterations from the normal in the number of circulating cells may be due to either physiological variations or pathological conditions. Concerning physiological variations, both the red and white cell count is lowest during sleep and increases variably during waking hours. The red cell count is increased in high altitude or any other condition which tends to lower oxygen tension. The ultimate cause of this corpuscular increase, called polycythemia, is due to the lowered oxygen tension of the atmosphere and consequently of the blood. This fact is of importance in aviation medicine today. Muscular exercise and certain emotional states cause a temporary increase, as a result of an outpouring of concentrated blood from the spleen. This is an emergency measure and, like that which occurs in high altitudes, is the response of the body to the call of the tissues for oxygen. Conversely, there is a reduction in the number of red cells at high barometric pressure; animals living in deep mines have a lower red cell count than those living at sea level.

With regard to the pathological conditions which we ordinarily have to deal with in hospital work, the red cell count may also be either increased or decreased. It is increased in such conditions as emphysema and other chronic conditions which interfere with the oxygenation of the blood in the lungs; congenital heart disease; chronic carbon monoxide poisoning, which is quite common today; chronic poisoning from chemicals such as arsenic used in the treatment of syphilis; gum shellac or aniline dyes used so extensively in industrial plants. Paradoxically, small repeated haemorrhages may produce polycythemia, which then represents an over-response of the bone marrow to successive blood losses.

Polycythemia vera, a primary disease affecting the red bone marrow itself, causes an enormous increase in the number of circulating red cells. Counts of from fourteen million to twenty million have been reported. The commoner finding, however, is the reduction in the number of red cells below normal, known as anemia, the causes and variations of which are legion. We will have to content ourselves with mentioning the two main types: primary, or pernicious anaemia and secondary anaemia. The second type may be due to gross haemorrhage, obvious disease, the ingestion of poison, or some such apparent reason. Frequently the cause is obscure: perhaps slight intermittent haemorrhage, low grade focal infection, faulty nutrition, excessive exposure to x-rays or radium, or to some obscure new growth.

A diminution of haemoglobin is the earliest positive sign of secondary anaemia. The exceptions to this rule are so few that with a high or normal haemoglobin, no further examination is necessary. If the haemoglobin is below normal and clinical evidence favours anaemia, further blood examinations should be undertaken. Once an anaemia is diagnosed and treatment instituted, weekly estimations of the haemoglobin alone will suffice to determine progress in the hypochromic types of anaemia. An increase in the amount of haemoglobin is of very definite use in the detection of dehydration, especially in diarrhoeas, vomiting, high fevers and in cases of severe burns. It is a more accurate index of dehydration than the feel of the skin or the appearance of the soft tissues around the eyes.

As in the case of red cells, the number of leukocytes may also be either increased or decreased in various pathological conditions. An enormous increase in number occurs in leukaemia — a hyperplasia, from unknown cause, of the leuko-

blastic tissue either in the bone marrow or lymph glands. The disease runs a characteristic course with a fatal termination.

A more common cause of a leukocytosis is infection and inflammation. The total leukocyte count is perhaps the commonest laboratory test applied for the diagnosis of acute appendicitis. With a typical clinical picture and more than 15,000 leukocytes the appendix is usually inflamed. If the count is below 12,000 the patient should not be dismissed as "a case of imaginitis". In the early stages of obstructive appendix, a colicky pain is present and there may be no increase in the temperature, pulse rate or leukocyte count. This is the type of appendix that becomes gangrenous and ruptures.

Leukocytosis occurs from infections caused by one of the pyogenic cocci, the pneumococcus producing the greatest increase. A low count suggests a bad prognosis in pneumonia. The increase in white cells may be non-bacterial in origin as in coronary thrombosis. Toxic conditions such as eclampsia, acidosis, intestinal obstruction and occasionally rickets cause an increase. A count of 25,000 or over, with little or no fever, suggests leukaemia rather than sepsis. Leucopenia, a decrease in white cells below 5,000, occurs in the following conditions: very severe infections which when less severe cause a leukocytosis; in typhoid, influenza, tuberculosis, measles, mumps, malaria, severe anaemias, agranulocytic angina, malnutrition, and poisoning by lead, benzol or radium.

Leukocyte changes are more valuable indicators in the early stages of disease than they are in marking the completion of recovery. The cell sedimentation rate tells more regarding the end-stages of disease. The sedimentation rate, too, is sometimes more sensitive in detecting disease than leukocyte counts or temperature estimations. A markedly increased rate, except in pregnancy, is nearly always a sign of disease, either inflammatory or malignant. It is only a diagnostic lead, however, and the physician must locate the site and nature of the disease. Its use is valuable in both the diagnosis and prognosis of inflammatory conditions. It is used extensively in evaluating the treatment of tuberculosis. It is also used in gynaecologic work and may help to differentiate between an ectopic pregnancy and an acute exacerbation of a chronic inflammatory process. It also aids in determining the best time to do non-urgent operations. Readings are valueless, however, after the third month of pregnancy.

To summarize: (1) if a patient complains of symptoms and the doctor cannot find any pathological lesion, a rapid sedimentation rate will warn him that there is likely some obscure, serious disease; (2) it is of value in prognosis, as recovery is well under way when the sedimentation rate approaches normal. It must be remembered, however, that this reaction is only a remote result of possible disease; therefore, too much significance should not be attached to it.

I read a little verse in a laboratory magazine one day. I can't remember exactly how it went, but it was something like this:

To get up bright and early, is healthy so they say —
But 6.30 isn't healthy, because it's only grey!
It's hurry, hurry, hurry, get the "pre-ops" before eight
Get the N.P.N.'s and van den Berghs, for breakfast can't be late!
"She'll need a *stat* transfusion", calls the doctor in the hall,
"The patient is a Group AB — and she has no friends at all".
"You're lucky there are no gastrics", says a helpful sister dear
"Requisition for two gastrics, please!" a nurse yells in the rear.
"I *must* get those admissions first", the poor technician sighs,

As she glances through *stat* C.B.C.'s piled nearly to the skies.
And at the very bottom, a *stat* blood sugar to be done!
Oh, the life of a technician is just a life of fun!

Author's Note: The material for this paper was obtained from *Laboratory Medicine* (Nicholson); *Clinical Diagnosis by Laboratory Methods* (Todd and Sanford); *Physiological Basis of Medical Practice* (Best and Taylor).

Infusion of Blood and other Fluids via the Bone Marrow

EDGEWORTH MURRAY

Nurses who are familiar with the care of children will know that their fluid requirement, in comparison with that of adults, is tremendous. A negative water balance is serious in both children and adults, but this state is reached much more quickly in childhood, and produces very serious consequences. Dr. Alan Brown states that: "the average adult will secrete from 1500 to 2000 c. c. of urine a day, while infants 8 to 10 lbs. in weight, or only one-fifteenth the adult weight, secrete half this amount in 24 hours. Viewed from another angle, if the average 150 lb. adult drank as much water weight for weight, as an infant, he would take 25 pints a day."

This is one of the biggest problems in a children's department. We know none of the infants or pre-school age children get enough fluids orally and, under certain circumstances, fluids given orally cannot begin to supply the demands of dehydrated infants who are actually ill, or of severe accident cases in young children. Neither will fluids interstitially or intraperitoneally meet the demands under certain circumstances; accidents, age, size and condition of blood vessels, can make the situation most difficult for those in attendance. When the circulatory depression is marked, and of some standing, it is difficult to introduce any substances into the veins, because in many instances they are impossible to locate. Even when the vein is cut down, the vessels may themselves have collapsed because of reduced blood volume and poor venous return. The walls of these veins in children puncture very readily, and it takes the skill of an expert, as well as patience and time, if the procedure is to be carried out successfully.

It is a comfort to know when these methods are impractical or have failed, precious time is being lost and the need is urgent, the bone marrow offers the ideal site for the introduction of blood or other fluids. The medullary canal is surrounded with a rigid bony envelope which is less likely to collapse and can, therefore, stand forcible injection without over-distention. Substances injected into the bone marrow cavity are taken up immediately in the venous circulation, apparently unchanged. Experiments on animals have proved this to be the case.

The needle is introduced into the sternum or tibia and, when marrow has been obtained by aspiration, the syringe containing the material to be administered is inserted into the needle, and the material is injected as fast as the resistance offered to it will allow.

Skilled Nursing Care in the Home

MAY L. PALK

Skilled nursing care in the home requires the same expertness in technical procedure, the same knowledge of disease, and the same understanding of the patient as is required in the hospital. Initiative and planning to meet the needs of the patient in his home environment are equally important to his recovery. Illness usually starts and ends at home with the hospital intervening in many instances. It is interesting to note that of every ten persons who are ill, approximately one person receives hospital care. The remainder are cared for at home and, as one doctor humorously told his patient, "when you grow tired of the loving imcompetence of the dear ones you call in a nurse".

Of the many patients ill at home, a considerable number do receive professional care either on a full-time or a part-time basis. There are many more, however, who need care but do not receive any skilled service. In Dr Weir's Survey of Nursing Education in Canada, published in 1932, it was revealed that five out of every eight patients sufficiently ill to require nursing care, were nursed by untrained attendants. This report came to us when there were many nurses not fully employed and now there are so many serving with the Armed Forces and in other fields that the situation is not improved.

The practice of nursing in the home is as old as nursing itself and under certain conditions home care may be both desirable and necessary. For example, the patient may be too ill or too weak to be transferred to hospital; hospital accommodation may not be available; economic reasons may interfere with his entering a hospital or may be instrumental in hastening his discharge while skilled care is still necessary; the illness may not require hospitalization; removing the patient from the home may necessitate placing the children elsewhere; the patient may be discharged from hospital to release a hospital bed; the patient may refuse to go to a hospital. Whatever may be the reason, when the nurse enters the home she respects the judgment of the patient and his family and adapts herself to the situation as she finds it. The nurse in the home depends on the private physician for diagnosis and specific orders just as in the hospital. She reports to him promptly and consults him on all matters pertaining to the patient's treatment and condition.

Instead of working in an orderly well-equipped hospital the nurse will many times carry on in modest surroundings with equipment improvised through her own ingenuity. If the patient is allowed to sit up, a card table makes an excellent improvised back rest and may be pinned securely in a sheet and fastened to the head of the bed. A wash-board, covered with a pillow case, or an inverted chair, may also serve to elevate the patient. A pillow, blanket, or cushion, rolled in a sheet placed under the knees and tied to the head of the bed, supports the patient and avoids slipping down in bed. Chesterfield cushions, if they are very firm, may be placed under the mattress either at the head or beneath the knees if only slight elevation is necessary. Weight of bedding at the foot of the bed may be relieved by a firm pillow or cushion; a cardboard box, with the bottom and one side removed, or a footstool placed on its side, may also be used. For a bed table and arm rest, an ironing board, padded and placed on two chairs, may be used and will afford the cardiac patient additional rest. A box with the two ends and side remaining and cov-

ered with bright cloth may serve as a writing table as well as a table on which to place the food tray. For the paralyzed patient, sand bags may be made in the home, or bags filled with bran may be substituted, or firm pillows used. Protection for the mattress may be obtained by table oilcloth, with cotton sewed to the ends to tuck under the mattress. Blocks may be used to elevate the bed to prevent backstrain when bathing, lifting and giving treatments to the patients.

Hypodermic therapy is a common treatment. For this purpose, a small tray, plate, platter, lid of a box or cake tin covered with wax paper, is a convenient method of keeping all articles together. The giving of an enema is an extremely common treatment and here again a tray enables the nurse to keep things together. A newspaper pad, covered with a bath towel, will protect the bed adequately. An improvised bed pan, made from a flat pan with a padded board over the end, may be necessary, a convenient cover is made from newspaper. Occasionally steam and medicated inhalations are ordered. A large jug, containing hot solution and covered with a large paper shopping bag with a three inch slit at the bottom, may be used. If an electric plate is available, a small basin covered with an inverted funnel with rubber tubing attached may be pinned to the bed.

In carrying out surgical asepsis in the home we need to recognize that, while we may have a relatively large clean area, we have a small sterile area as compared with the hospital where we have the larger sterile field of sterile towels, sheets, etc. Asepsis may be as well maintained in the home as in the hospital if this point is kept in mind. In the home there will not usually be sterile sheets, towels or gloves for the nurse's use; the articles used will be sterilized by boiling rather than autoclaving. Dressings can be sterilized in packages containing gauze fluffs and a protecting pad for one dressing only; these can be baked in the oven at a temperature of 350 degrees for one hour, half an hour with a pan of water in the bottom of the oven, then for half an hour after the water has been removed. A fork and spoon for lifting articles will substitute for hospital forceps. Soiled dressings to be burned are placed in a paper bag; dressings to be washed are placed in a separate bag. The bed is protected with a towel and newspaper.

Catheterization and bladder irrigation are common treatments in the home care of the patient. The irrigation is often given through a permanent catheter or a supra-pubic tube and we again keep in mind that we have a large clean area but only a small sterile area. Equipment includes catheters, forceps, tablespoon and fork for removing articles from the boiling basin, instrument basin, bowl for cleansing patient, absorbent cotton for cleansing, a receptacle for receiving urine, protection for the bed, paper bags, a bottle for the specimen. For bladder irrigation, add an irrigation funnel, rubber and connecting tip, and a jug for solution. It is advisable to wear a mask for all surgical procedures and for catheterization and bladder irrigation.

Problems arise in the home which have not been encountered in the hospital care of the patient. An over-protective or unwise mother may interfere with the treatments which are necessary for the child. Small children may make it extremely difficult to provide the rest and quietness essential to the patient's recovery. The financial worry of the breadwinner who is temporarily incapacitated may delay his convalescence. Sometimes an aged person becomes antagonistic if he suspects a nurse is attempting to direct him.

These problems require of the nurse not only a knowledge of the diseases and an expertness in technical procedures, but also a real understanding of people, and a

recognition that their behaviour is usually a symptom. The nurse needs to analyze each individual situation and try to learn how the family and the patient feel and how they can best be assisted in working out a solution, whether it be procuring household assistance, making plans for institutional care, providing occupational therapy for the patient, or improving the family's nutrition. The nurse can help in the solution of the problem but can not take over completely from the family without having them feel less effective. This self-respect of the family is very important and is best maintained if they make their own decisions.

The nurse of yesterday was chiefly occupied in relieving the suffering of sick people; the nurse of today is equally interested in curative nursing but also accepts the opportunity which bedside care provides for the teaching of health not only to the patient but to the entire family. Many nurses are alarmed by the term "teaching" and think of it as formal classroom instruction. But the nurse is continually teaching, either by the direct or indirect method. By what she is, by her attitude to health practices and by the type of care she gives the patient, she does her most effective teaching. In proportion as her nursing care is satisfactory, opportunities come to her for health guidance and, to the extent to which she is a genuine understanding person, will her help be sought.

The nurse is constantly asked questions related to healthful living, and if these opportunities are accepted, she may help to bridge the gap between available scientific knowledge and the application of that knowledge in the homes of the community. However, health education cannot be forced upon people, it must be sought. Many opportunities occur in home nursing when the nurse may help to interest the patient and the family in these matters of health, thus helping to take up the slack between laboratory finding and the personal practice of healthful living.

The patient who is acutely ill many times seizes the opportunity to tell his fears and anxieties to a tolerant understanding person who is not part of the family situation, yet understands what he is talking about. This leaves the patient feeling that he has lost some of his troubles in the act of telling them. The nurse is someone who will take charge of the situation and think for him. The unloading of these anxieties and fears can be of invaluable aid to the patient and also assists the nurse in a better understanding of the emotional needs of the patient and his family. Nursing in the home impresses upon the nurse the degree to which illness of one member of the family upsets the entire household. Many times the convalescent patient is difficult and seems to capitalize on the attention expected by an invalid. Great skill is required on the part of the nurse to help strengthen the incentives to get well.

Then we have the chronically ill group, many of whom are cared for at home such as the patient with diabetes who may or may not be incapacitated; the patient with cerebral hemorrhage and residual paralysis; the patient with carcinoma; the patient with some circulatory condition or degenerative disease. We must not overlook patients with arthritis and rheumatism, those illnesses of which it is said "they cripple most and kill least".

The treatment of the patient with a chronic illness, in which return to normal is not expected, is to arrest the disease and encourage the patient to resume as far as possible his place in the family and the community. If the nurse can help to instil hope and the will to get well, it is the greatest tonic for the patient. Older age groups like to retain their social contacts in the community and I am reminded of some of the elder-

ly patients in our districts — patients who receive care on a visiting basis for a treatment that necessitates professional care once daily and probably takes about an hour. Occasionally these patients have so many social engagements that the nurse's visit causes no little inconvenience. In the case of the over-ninety-year-old it interferes in the summertime with his seeing the ball games. It conflicts with the luncheon at the club for the over-eighty-year-old patient, and must be worked in between the attendance at three church services on the Sabbath for another elderly person. While this may sound humorous, from the patient's point of view it is the difference between "living" and, as some one has termed it, "the death in life", which can so easily be true of the chronic and the aged. If he can be made to feel that he still has a contribution to make, it does help him to live one day at a time. He has a handicap — yes, but one to which he must adjust.

Dr. Boas, who has made several studies of the chronically ill, states that an arthritic or paralytic receives considerable benefit from using his limbs and joints in doing things for himself. These exercises are frequently as beneficial as are physiotherapy treatments. Whatever may be the chronic illness the patient usually needs to be helped to live with himself and to feel less of a burden to others. There is increasing emphasis on assisting the mature adult to prepare for senescence as the child prepares to become an adult. Far more can be accomplished for the aging than for the aged. We have for some time thought of the patient as a person, not a diagnosis, but now we go farther and think of him as a person among persons, influenced by the household and also influencing the household.

Whether the patient is acutely ill or chronically ill, if he requires skilled nursing he turns to the graduate nurse and, whether in hospital or home, we shall endeavour to give him the highest standard of nursing care of which we are capable.

In a Concentration Camp in China

SUSIE KELSEY

Until Pearl Harbour, I was working in a mission hospital in North China where the Japanese had been in control for some years. But on the outbreak of the Pacific war I became an enemy alien and was taken into "protective custody" by the Japanese military authorities and was confined in my own home for over a year. However, the hospital continued to function under our Chinese staff and is, I believe, still serving the sick and suffering in a wide district.

In March, 1943, I was taken to a civilian internment camp in Wei Hsien, Shantung, where I found myself part of a community of nearly eighteen hundred westerners of many allied nations. This busy, complex society was a great contrast to my loneliness and isolation in the interior and, in spite of various discomforts, I quite enjoyed the change. The accommodation (formerly a large mission compound) and the food were provided by the Japanese but all the internal organization and work of the camp were undertaken by the internees themselves. On arrival at the camp

our most pressing problems were the allotment of quarters and the provision of meals. We soon had the kitchens organized, only three of them for the whole camp, so cooking had to be done on a large scale and at first nearly all of us had to do our share in the preparation or serving of the meals. When we could turn our attention to other activities, men and women with teaching experience were registered and schools were soon started for the children. Later, adult classes and lectures were given on a great variety of subjects. With nearly half the camp missionaries of Roman Catholic or Protestant denominations, the religious side of our life was not neglected. There was also a recreation committee and baseball matches vied in popularity with high-class concerts and bright variety shows. A jazz band played for dances and a Salvation Army band on Sundays.

The health of the camp was an important matter so doctors and nurses were early asked to register and to attend a medical meeting. I was glad to find my niche in that branch of service. There was a good hospital building on the compound but it had been thoroughly looted when the Japanese first came in. We were given the use of the first floor for a camp hospital but the two upper storeys had to be used for dormitories and were occupied by Dutch priests. Our first job was to clean up the place and quite a job it was, but doctors, nurses and other volunteers went at it with a will and soon had it ready for equipment. A small amount of this was salvaged from the looted hospital and a good many supplies had been brought into camp by doctors and nurses from Peking and Tientsin who had been able to rescue them from their own hospitals. All such supplies and many drugs were freely given to the hospital for the use of the community as a whole. Later on, the internees were asked to contribute $60 each (Chinese currency) by a promissory note on our respective governments and the Swedish consul was able to loan us the amount and to expend it on drugs and equipment as requested by the medical committee. This was a wonderful help.

Sufficient beds were available but the patient had to bring his own mattress and bedding into hospital with him. This meant that friendly neighbours had to rally round to carry the patient, on a stretcher or in a chair, with his roll of bedding from his dormitory to his hospital bed. Not infrequently the doctor who ordered hospitalization would also lend a hand in bringing in the patient.

We were fortunate in our staff for many doctors and nurses had ignored consular advice to leave China before the war broke out and, being interned in our camp, promptly offered their services. Our hospital superintendent was the leading surgeon in the Peking Rockefeller Institute and our nursing superintendent was the former superintendent of nurses in that famous hospital. We had a well-known dentist from Peking, though he had little material to work with, and an eye specialist, an octogenarian who had long retired from hospital work though continuing a private practice, who could tell hair-raising stories of the Boxer days. His years might well have excused him from camp duties but as soon as he arrived he volunteered for work and continued his clinic until repatriated.

Almost all the nurses had held executive positions in Chinese hospitals and we now enjoyed the chance to do humble practical nursing. Some visited the less serious cases whose friends could care for them in their rooms, others worked in the out-patient clinics and others in the laboratory, pharmacy or on the wards. The hardest worked were the nurses in charge of the combined operating and labour room who not only had to prepare and sterilize

their supplies and to assist at operations or maternity cases but also had to wash all the linen afterwards for we had no hospital laundry. For our first baby, Abraham Moseson, whose elder brother had been born in Palestine, we washed all the diapers on the ward with our personal soap, but later we became too busy and the mother's friends had to take the washing home. Fathers, whose first-born arrived in camp, were quite proud of their wash. We had eight babies born in the six months I was at camp, among them a fine pair of twins.

While we had a fair number of surgical cases, most of our patients were medical ones. During the summer months, with unsatisfactory sanitary conditions and many flies, these were chiefly gastro-intestinal diseases from mild diarrhoeas to serious dysenteries, with occasional outbreaks of food poisoning. There was little contagious disease though children with whooping cough and chicken-pox had been sent to the camp. One case of typhus gave us quite a scare but prompt delousing prevented its spread. Tuberculosis was present throughout the camp but not much of an active nature. We had all been frequently vaccinated for smallpox and inoculated against typhoid and cholera so we saw none of these terrible scourges of the East. As the camp had only been in existence for a short time, the malnutritional diseases had not yet become apparent though in Hong Kong and Manila, where civilians had been interned for two years, they were very serious. I fear they will become more common as conditions deteriorate.

When in September, 1943, the repatriation of American and Canadian civilians on the "Gripsholm" was arranged, the hospital staff was sadly depleted for although only about two hundred and fifty were included from our camp, a large proportion of doctors and nurses were among the fortunate number. However, enough were left to carry on the good work, English doctors and nurses and the remaining Americans arranging to bear more of the burden than before. In our joy at regaining our own freedom we cannot forget the friends whom we have left behind and whose sufferings will increase as time goes on and would ask for the sympathy and prayers of all Canadian nurses for them.

Beyond Imagination

A feature article in the *Nursing Times* of April 22, 1944, presents abstracts of a lecture on "France of Today" by Madame Cathala. Any nurses in Canada who have been considering the possibility of volunteering to assist in the vast rehabilitation program which will confront the allied nations in Europe should ponder well these excerpts from Madame Cathala's address:

We must face the truth and realize that when we are at last able to help relieve the people, we shall have to bring to the task all our strength, will-power and delicate love, for many of them have lost everything — their homes, their children, their parents, their health, even their hope and their desire to live. Their condition is beyond the imagination of civilized man. You must not think, if you go out to Europe that you are going to have an interesting or a marvellous experience. You must realize that what you are going to do amounts almost to a religious work: you must be prepared to give all your life and strength for you are taking on one of the most difficult of undertakings. Many of the people are completely disorientated and you will have to help them to want to live.

You will not be much use unless you know the language. Although most educated people in France can speak English, it is not they so much as the working people who need your help. Many of the concentration camps are filled with all kinds of refugees . . . but they can all speak French . . . You must realize, however, that they have suffered terribly and this has made them so easily hurt, so touchy about everything, especially things which concern their independence and national life.

HOSPITALS & SCHOOLS of NURSING

Contributed by Hospital and School of Nursing Section of the C. N. A.

J.I.T. Methods of Teaching

HELEN M. KING

Just recently twelve members of the graduate staff of the Vancouver General Hospital attended classes given by a Job Instruction Training expert. We were curious to know how industry is tackling the problem of training numbers of inexperienced people quickly. From all accounts these methods have been accepted in war plants and in the Air Force with excellent results. There is nothing new in J.I.T. methods: they are based on an understanding of human nature, psychology and plain common sense. Any of us, who have studied the principles of learning and teaching, meet these same well tried principles just dressed up in overalls brought up to war demands, and geared for the production bench.

The pressing need of workers in industry has necessitated methods of teaching which will produce workers who can accomplish a job with the maximum efficiency and the minimum of mistakes. Workers must do their job quickly, safely, correctly, and conscientiously. Hospitals are experiencing the need of initiating new workers into jobs quickly and thoroughly. The trend is towards employing subsidiary workers in the ward situation. Teaching these new workers will be a problem in the maintenance of a smoothly running institution.

The slogan of the J.I.T. is: "If the learner has not learned, the teacher has not taught". Their process of teaching is broken down into four main steps: preparation, presentation, performance and follow-up. Preparation consists of many things. First of all the teacher must have a timetable planned and be armed with a break-down of the job, of which more later. The zone of work must be well prepared with all necessary equipment and tools in good working order. Diagrams and descriptive plans must be provided for reference.

The next step is the preparation of the learner. A very nervous newcomer is a poor prospect for rapid learning. Strain and tension is very unwelcome, therefore the teacher aims at putting the newcomer at ease by a genial welcome. J.I.T. recommends a tour of the whole factory or plant to stimulate interest and as an introduction of the new worker to the whole working of the organization. The teacher finds out the experience of the new member and of what she is capable.

J.I.T. stresses the importance of teaching only a digestible amount at a time and of the importance of not overstuffing. Never attempt to teach too much in one lesson. Therefore in the presentation, the selection of an assi-

milable amount of learning is the first necessity. It has been estimated that seventy-five percent of learning is through the medium of sight, and only eleven percent by means of hearing. Explaining how to do a job must be accompanied by showing at the same time and, when showing a learner how to do a new job, the learner must look at the procedure from the same angle as the teacher. To illustrate these two points, the J.I.T. trainer first told us how to make a fire underwriter's knot without showing us. Not one of us could do it. Next he took a piece of electric wire and showed us how to do it but left us sitting opposite instead of beside him; consequently, when we tried, we were very confused as we had to translate it all backwards.

Point out the importance of the new job to the learner and of what significance her part is in the success of the whole. The teacher then shows each step of the procedure slowly, making marked pauses to allow time for it to sink in, and waiting long enough between each step for the learner to photograph mentally the appearance of the work. Emphasize key points which must be remembered—links which join one change in the situation to the next.

The performance follows with the teacher going through the procedure, the learner telling the teacher what to do at each step. If the learner gives wrong instructions, the teacher does it incorrectly until the learner sees her own mistakes and corrects it. During this repetition the teacher asks questions—why, when, what, and how? The worker then takes over the job, and she explains each step as she goes, the teacher asking questions to make sure she understands the reasons for each step. The learner then repeats the procedure several times, still under supervision, until the teacher is reassured the lesson is well learnt. A word or two of praise is given to build up confidence and the teacher puts her on her own, telling her to refer to her diagrams if necessary but not to ask other workers for advice, as the teacher intends to return shortly to assist in any difficulty. The new learner gains confidence when left without supervision and gets into her own stride.

The follow-up is the checking which the teacher must do, to insure against mistakes or faults. This is frequent at first, but is gradually tapered off as proficiency is gained. The break-down of a piece of work is an instructor's guide and a learner's reference. Two columns are made, and on one side are the steps in the work. and opposite each stop is the key point. A step is defined as a definite change in the situation; it is an assimilable amount to take in at one time. Key points are important items emphasized to ensure correctness, such as measurements, certain weights, directions right or left, distances to and fro and so on. Hazards and dangers must always be pointed out, also tricks or knacks in doing things.

During this course each one of us had to put on a demonstration of teaching some short piece of work obeying all the J.I.T. rules. Inexperienced students, V.A.D's and ward aides were brought in as learners, small lessons being specially chosen for demonstration. According to J.I.T. standards, in hospital life we teach far too much at a lesson, and we found it difficult to find some item of learning which was considered digestible. On the whole, student nurses must be excellent material to teach; in the press of many things, how very sketchy instructions are at times, and how quickly we expect them to "catch on". The marvel is that they do "catch on" at all. The hospital situation does not make it easy to take a new student aside and spend the time one should in teaching something new. But yet one wonders sometimes if it would not be economy of time in the end if one did.

The J.I.T. trainer wanted to know

if these methods were not applicable in hospital life. In many ways such methods of teaching have been carried out in training schools, whether by accident or design it would be hard to say, but nurses are not dealing with inanimate objects as are workers in industry. Once you have taught a girl to do rivetting she can go on rivetting in exactly the way till the cows come home or the ships come in, but with nursing you can't do the same thing the same way twice for a patient — no two patients react the same way twice, but we had to admit the principle of the methods were sound, and that as far as hospital life was concerned, time was the stumbling block.

Opportunities in Clinical Instruction

ELDA CAMERON

In 1943 a clinical instructor was appointed to the staff of the Saskatoon City Hospital. This was a new venture and considerable time and thought were given to planning her responsibilities and programme. At a staff conference her duties were outlined and it was stressed that she was to assist the ward supervisors with their ward teaching, but not in any way to replace them.

The clinical instructor worked under the Nursing Office without responsibility in that office. She did not assume any responsibility for ward administration, nor for assistance to doctors, and her only responsibility to patients was in supervising the nursing care and procedures performed by student nurses. She worked in very close harmony with the nursing arts instructor in order to correlate classroom and clinical teaching and the wards were kept informed when students might perform new procedures. The students soon realized her value and went to her freely for help and advice. All new procedures were supervised when performed for the first time. This was most valuable as such treatments take longer and the busy ward supervisor often has many interruptions during a lengthy treatment. Assistance was given in charting new procedures.

The ward supervisors were encouraged to continue with their ward teaching and given help when necessary. They were most co-operative in notifying the clinical instructor regarding new treatments or other available experience. The clinical instructor assisted students with the organization of their work and helped them with difficult nursing problems in an effort to teach good nursing care by demonstration as well as by theoretical instruction. Criticism at all times was constructive. She also co-operated with the supervisors in planning morning circles, conferences and formal clinics, because she could thus indicate the students who required specific experience.

Formal clinics were organized by the ward supervisor in which three or four students took part, and possibly a doctor, an interne, or a diet nurse as the case indicated. An informal discussion followed. The clinic concluded with the supervisor or clinical instructor consolidating the material by re-emphasizing the important points. Clinics were posted in advance so that as many nurses as

possible might be present. General staff nurses frequently attended.

Conferences with student nurses assigned to their first term of night duty were also conducted by the clinical instructor. Some of the topics chosen were: the responsibility of the junior night nurse; ward routine; review of difficult procedures or complicated apparatus such as continuous gastric suction, oxygen tent, gauge and humidifier. A review of any procedure requested by a student was arranged. Conferences were conducted for the newly capped nurses assigned to the medical and surgical wards. The class was divided into groups for better teaching and, by means of clinics or conferences, dealt with the various types of patients they were nursing. Each student was assigned a study of one of her patients and, after she had outlined the nursing care, the clinical instructor questioned the other students individually, reviewing the nursing points only and requiring reasons for all answers. Ward difficulties were also discussed.

Conferences for the senior class were started when it became necessary for senior students to assume assistant supervisory responsibilities and to replace general staff nurses. Again the class was divided into groups. A list of topics was planned and one topic assigned to each student who prepared and presented it to the group. General discussion followed. The students were most interested, asked for information from supervisors and did considerable reading from such texts as The Hospital Head Nurse (Wayland), Ward Teaching (Taylor), the Supplement to the Curriculum, and Ward Teaching (Janzen). The topics included ward routines; duties of internes; ward housekeeping; standing orders; notification of doctors regarding patients; admission of patients; supervising junior nurses; checking charts. In all conferences the group was small and took the form of a round table discussion following the student's presentation of her material. Discussion was free and the general atmosphere was informal. Individual conferences were held with supervisors or students as necessary.

An individual record was kept by the clinical instructor of all procedures satisfactorily performed under supervision. Attendance at formal clinics was not compulsory, but was required for all conferences. All time spent was considered time on duty. A list was made of both those attending and those taking part.

We feel that our programme has proved its value. It has been most gratifying to note the interest and co-operation displayed by the staff, both graduates and students, toward the various activities and undertakings of the clinical instructor.

September – the Convention Number

Following the custom established several years ago, the September issue will be twice the usual size and will contain the addresses and reports given at the Biennial Meeting in Winnipeg. Because of limitations due to paper rationing, it is urgent that you place your order for extra copies before the end of August if at all possible. While individual copies of the *Journal* ordinarily sell for twenty cents, the double-sized issue will be sold for forty cents, although there is no increased charge to our regular subscribers. You cannot afford to miss this special issue, so place your order at once.

PUBLIC HEALTH NURSING

Contributed by the Public Health Section of the Canadian Nurses Association

The Nurse and Venereal Disease Control

PAULINE CAPELLE

For the past four years venereal disease has held the spot-light, not only as a major public health problem but also as a saboteur of our war effort. As such, it presents a challenge to every nurse in this Dominion. To date, nursing has been an almost untapped potential in venereal disease control. While some contribution has been made by a few nurse specialists, the profession as a whole has not accepted its responsibility, due to the fact that the majority of us are not sufficiently well informed on the subject.

Why are the venereal diseases major public health problems? Why do they so sabotage our war effort? While there are innumerable reasons, the chief ones are as follows:

1. They are the most prevalent diseases of our day and generation. It is estimated that 300,000 people in Canada have syphilis and many times that number have, or have had, gonorrhoea.

2. Syphilis and gonorrhoea are young people's diseases; 75% are acquired before the age of 35.

3. Syphilis ranks with cancer and heart disease as a major cause of death.

4. They interfere with the propagation of the race. Syphilis causes abortions and still-births, or else the birth of a living syphilitic child. Gonorrhoea causes sterility in both male and female.

5. The cost of caring for the complications of syphilis in Canada is estimated at two dollars per capita. In addition, there is a tremendous loss to industry in time, compensation costs and costly accidents.

6. As social problems the venereal diseases have no peer. They frequently cause divorce and the breakdown of family life. Innocent wives become infected and give birth to handicapped children. Any victim of syphilis may become a hopeless invalid; should the breadwinner be so afflicted, the standard of living for the whole family is jeopardized and frequently they become public charges. No other diseases known to mankind, carry such tragedy and suffering in their wake, nor have such far-reaching effects.

How does the nurse fit into the picture? Her work logically falls into two main channels — education and epidemiology. In spite of the publicity that has been given to venereal disease, the full significance of the situation has not yet become common knowledge to the average Canadian. The majority of people are still being wed without pre-marital blood-tests, countless women are still having babies without pre-natal blood-tests, the vast majority of schools still leave untaught the fact that syphilis and gonorrhoea are common communicable

diseases. These are facts obvious to the most casual observer. Moreover, they are ugly facts — they indicate that prudery has successfully hidden the light of scientific knowledge and kept it from accomplishing its work of healing. We may ask ourselves, therefore, what is the remedy and what part can the nurse play in solving the problem.

First the nurse must secure adequate and correct factual information. She should know the incidence, modes of transmission, course and infectivity, mortality rates, costs (both economic and social) of the venereal diseases in her own province, country, and other parts of the world. She should be familiar with the socio-economic conditions which breed venereal disease: slums, commercialized prostitution, certain dance halls, beer parlors, cafés, rooming houses, indifferent law-enforcement, etc. and be able to suggest constructive policies for their amelioration. The nurse, as a health worker, must have at her finger-tips knowledge of community resources for the control of venereal infection. These will include facilities for diagnosis and treatment, epidemiology, education, law-enforcement, and means for social assistance and rehabilitation.

For the nurse with a sound foundamental knowledge of venereal disease and its control, numerous opportunities present themselves for the dissemination of information to others. The institutional nurse, through her daily contact with her patients, has an opportunity to interpret the various phases of the disease to those suffering from a venereal infection. The fact that treatment renders syphilis non-infectious should be stressed. The patient must be made aware that it is his responsibility, to the community and to himself, to continue therapy until the doctor says he is cured. The tactful nurse may be able to elicit important information about the patients' contacts which will enable field workers to bring these people in for examination and treatment if necessary. These contributions on the part of the institutional nurse would be a powerful aid in controlling the spread of venereal infections, if every nurse would co-operate.

There is today a growing health consciousness which we must capitalize. People are interested in the problem of venereal disease. In many cases the interest may be morbid, but a well-informed nurse with a completely objective attitude can mould that interest into a healthful, aggressive force which will demand and get action. In this connection, one specifically thinks of:

Popularizing pre-marital and pre-natal blood tests;

Wiping out unsavory community conditions, such as commercialized prostitution and various forms of facilitation and facilitators;

Promoting healthful community recreation;

Establishing social rehabilitation of delinquents and prostitutes;

Developing modern ways and means of making a high moral standard for boys and girls so attractive that they will choose it of their own volition.

The glamour of immortality will soon be debunked if something infinitely better and just as modern is presented.

The public health nurse can assist with the organization of community efforts to control venereal disease. These might include pre-marital and pre-natal blood testing campaigns, and routine physical examinations including a Kahn test for all people in the district. Her office should be the centre from which authentic information on venereal disease might be obtained. Frequently, women's groups like to make a study of some public health problem and venereal disease is a very timely one. Teachers need help to present the question of venereal disease to their senior students and the nurse should be able to provide it. Nurses may use the local press and radio to further health projects of which ven-

ereal disease might be one. They may also be guest speakers at various local organizations, particularly Parent Teachers Associations and young people's groups. The public health nurse is the logical person to interpret the health angle of venereal disease to welfare workers, clergy and law enforcement agencies.

Understanding, tolerance, skill, complete objectivity, and a genuine desire to help the patient are essential for success in contact-tracing and case-holding. All-important are good relationships with the physicians of the community; without their co-operation venereal disease control will never be entirely successful. To find contacts one must know the initial case. At the present time, in many cases only the private physician has this information. It is up to the nurse to so convince the doctor of the value of her services that he will be willing to make use of the services that are available.

Canada stands at the cross-roads. The physical well-being of the citizen of tomorrow depends upon how well we of today use the armamentarium of scientific facts at our disposal. Venereal disease can be cured, it can be controlled, it can and will be eradicated if everyone assumes his or her share of the burden. Nursing will have a major role to play and nurses will help to build for that happy tomorrow where the dream of "Freedom from Disease" will become a reality.

Rural Nursing is a Full-Time Job

MARGARET S. SMITH

The public health nurse in the rural community has many opportunities to serve of which her urban sister knows little. She has a better understanding of her patients because she is a part of her district. Generally, she lives right in the community and takes an active interest in local activities. In this way, she learns a great deal about the customs and ideals, the habits and attitudes of those with whom she is mingling, and encourages the leaders to work toward higher standards of healthful living. By having contact with the family in more than one way she becomes acquainted with every member of the household and is able to discuss various problems while visiting in the home.

A generalized programme has many advantages in the more sparsely populated areas, from both the standpoint of costs for the service and transportation. Since all branches of the work include some home visiting, the nurse meets the patient on his own ground. It is in the home that she really comes to know her families. She must learn to adjust herself to the various situations that she may meet in the day's work. Each brings new problems to be studied. For example, while the primary purpose of the visit may have been some care for a school age child, an infant welfare difficulty may be much more important to the mother and require immediate help; or during a routine visit to a tuberculosis patient, a new prenatal case may be discovered and supervision commenced.

Fortunate is the rural nurse who has a rural background. She understands the psychology of these people living in more isolated areas, that they are slower to

grasp new ideas and are unaccustomed to hospitals, clinics, and other facilities the urban population has come to expect. Many questions of abnormal tonsils or teeth may be freely discussed when the farm folk realize that this nurse understands them and their everyday problems. By indicating a practical knowledge of rural activities and farm duties, casual remarks in general conversation on health matters will be given greater attention and bring forth good fruit. In the rural area, the churches are often strong allies of the rural nurse. The church hall may be the only place large enough for a child health conference or chest clinic. Usually it is fairly centrally situated, too, which is an asset.

Rural nurses have long distances and travel difficulties to overcome. They are out in good weather and bad, and do not always accomplish the day's work as planned. They are sorely tried when the usually faithful car refuses to go and when the only available telephone is far distant; when even man-power to come to their aid is scarce. To have to be towed five to six miles to a garage, or to wait to be pulled out of a snow-bank or the mud, takes time and patience of which their urban colleagues know nothing.

Co-operation with various social agencies is very essential to good work, but these are often not available to the public health nurse in the country. She has to be a social welfare worker as well. Many behaviour problems are brought to her attention as well as difficulties in domestic relations. She is often expected to give aid and advice. Often she is far distant from service clubs who might assist in providing care for a crippled child or some other worthy cause. Ingenuity, common sense and skill in arousing community interest will help her. Sometimes she finds a child physically unfit for school and for whom there has not been any attempt made to provide elementary school work. Through the proper contacts, a correspondence course may be started, and grateful parents are ready to give their co-operation to the understanding nurse.

Many times during the course of a home visit the nurse will find that there is a chronic invalid or someone who is likely to be in bed for some time with very incompetent nursing service available. Other duties are put off while she demonstrates bed-side care and explains the reasons for the various treatments. Simple dressings are often taught and the necessity of sterilization and cleanliness of equipment stressed. When a young mother returns from hospital it is often the nurse's pleasant duty to demonstrate the care of the infant.

Women in rural areas seldom have the privilege of attending nutrition classes. Many of them are out of doors working when such talks are being broadcast. Again the public health nurse comes to the rescue and gives practical ideas on the necessity of milk, vegetables, etc. This knowledge is often given as the mother is preparing a meal or as the nurse is being shown the vegetable garden, peculiarly appropriate opportunities to provide this information. School lunches are a profitable topic for discussion and frequently, when the neighbourhood is sufficiently aroused, the outcome may mean an improvement in school equipment, and in many cases, a more intelligent interest in the whole problem of nutrition.

Yes, there are difficulties but these are far surpassed by the satisfaction of a good day's work, and the knowledge that she is welcomed and appreciated by a large majority of the people. Maybe she is not told of this appreciation in flowery phrases but a smile and a grateful look is all she needs to be happy on the homeward way.

GENERAL NURSING

Contributed by the General Nursing Section of the Canadian Nurses Association

A Married Nurse Returns to Duty

Mrs. A. Chisholm

I wonder how long it will take me to get on to things. I made out alright with baths this a.m. Remembered how to strip a bed properly and to start bathing patient on the side fartherest away from me. Seems to take longer than it should though. Oh well, perhaps tomorrow I'll do better.

Sinapism B.I.D. — what in thunder is a sinapism — something new or something I've forgotten? Let's see, he's got a chest cold, perhaps pneumonia. Why of course they are just mustard plasters — haven't heard them called anything but that for years — and B.I.D. is twice a day.

Medicines — how on earth am I going to find them all and what are all these new ones that are ordered? I've read about some, but I don't know what they are all given for. Oh well, I can always ask if I'm not sure.

Patient to be catheterized. Tray is all set up, catheters, kidney basins, round basin, scrub brush. This patient is rather nervous so *you* can't be that way. Just pretend you've been doing this every day for years. It worked — hope my technique was alright. I must read up on these things.

Intravenous — everything seems to be here, but I've never seen this new type of container before. Now what did Miss Jones tell me to do? Take the top layers of. The doctor will attach the tubing and you hand it up. Good grief! I forgot the standard. It's a good thing the doctors have a lot of patience. There, it's going. I will be more help next time, I hope.

Something going on in minor operating room — tonsils — will I wait on? Sure, just have to look after the suction machine. Watch the patient for haemorrhage. I wonder what I'd do if he started — sure hope he doesn't. Wonder how long I can leave him in safety. If I checked every five or ten minutes, nothing much could happen. Oh, stop being so jittery or you'll scare the poor man into a haemorrhage. His condition is good, so be sensible and follow orders. There, you see he's alright and it's time for you to go off. I didn't sleep much that night, though.

Prepare a patient for an abdominal. Let's see now — shave abdomen — that looks clean enough. What next? Oh yes, ether, alcohol and paint with iodine and put sterile towels and a binder on. False teeth out, hypodermic given. Now I wonder what I'm to do in the operating room. Hope I know where to find everything I'm asked for. Fasten patient down—do anything the scrub nurse asks you to — don't go near that

table, lady, it's sterile. Tie up doctors' gowns — turn down sheets, unfasten binder. Now they are starting — hope nothing goes wrong because I'm not sure I'll be much help if it does. Well, thank goodness that's over. Wonder if I made that anaesthetic bed properly. Too late now, he's back in-it.

A new patient admitted — emergency appendectomy. This can't be right, we just had *one* operation. Will I scrub? But I haven't scrubbed anything but floors and walls for years. Oh well, you might as well learn. Anyway, all you do as second scrub is what the other nurse tells you to. If you'd paid more attention when you were in training you'd have known the procedure. Mask and cap on, ring and watch off. How long do you scrub your hands? Can't ask out loud — the doctors are here. Seems to me it's ten minutes — can't be that long but better be safe, anyway you need a few minutes to relax so just scrub away. Now, find out about sutures, and anything else you are supposed to know. Don't give a piece of silkworm for the peritoneum, or a round needle for the skin. Sure seems hot in here — I would like a cold bath. If I come through this without a heart condition, the doctor will have two lives saved instead of one. Oops, there goes a glove — why you didn't take time to file your nails down more is beyond me. Everything seems to be going along fine. Wonder if anyone notices how jumpy I am. They should be able to hear my heart pounding — sounds like a threshing machine. Guess I'm imagining a lot. No one is paying the slightest bit of attention. There, it's all over. Now what were you worrying about? That wasn't much harder on you than your first tea.

Two ambulance cases coming in from the mine — one with a broken leg, the other a head injury. Wonder, if it's anyone I know. Bed's all ready, doctor called, instruments boiling. Hope I didn't leave anything out. I never will forget the look the doctor gave me, that last suture case I had. Here they come — give them each a hypo and help get these clothes off. Poor fellows, sure look as though they'd had a shaking up. There, they are both in bed and seem to be comfortable. What a night!

Relieving on maternity this afternoon with a patient in labour. Oh well, you just call the staff nurse over for the case. There goes a bell. Oh! Oh! hard pains — better get her to the case room. It's partly set up. Lady, I'd like you to have your baby, but I hope you wait till after three o'clock. Guess I'd better get things all ready and call someone in for advice. Be on the safe side — get her draped and call the doctor. Sure hope I remember how these things go on. *Three o'clock — relax!* (On the morning after the patient still hadn't had her baby. Next time I won't rush things so much.)

And here's another case — a multipara. Let's see, sterilizer on, instruments out, basins and linen ready. It's early in the day so you *will* have this one. Don't get panicky like you did with that last patient. I'll still feel better when I've got her in the case room. This is hard on the nerves. Another pain — seems harder. Better get another nurse and call the doctor. Won't it be awful if I called him too soon — or, heaven forbid, too late. There, everything is ready. There's the doctor now. Ten minutes — fifteen minutes — lady, if you let me down and don't have your baby pretty soon, I'll die. Oh! why did I call him? There, that's better. I wasn't wrong after all — a lovely baby boy — seems all right. Now placenta — pituitrin — patient back in her room. Babe oiled, bathed — and I guess that's all but the cleaning up.

Well, I'm not afraid of anything now — *much!*

Notes from the National Office

Contributed by KATHLEEN W. ELLIS

General Secretary and National Adviser, The Canadian Nurses Association.

General Meeting—1944

By the time the July issue of the *Journal* appears the twenty-second convention of the Canadian Nurses Association will be over. Already it is reported that all reservations at the Fort Garry Hotel have been taken. Full accounts of proceedings and reports will appear in the September number of *The Canadian Nurse*.

The following announcement was received too late to be included in the programme:

A General Memorial Service will be held at the Winnipeg Cenotaph at 7 p.m. on June 27, in memory of those Nursing Sisters who lost their lives in the sinking of the "Llandovery Castle", June 27, 1918.

It is very fitting that such a service should coincide with the biennial meeting, when many nurses will be present to pay tribute to those who gave their lives in the last Great War.

We are reminded daily that at the present time nurses are sharing the hazards of total warfare. The Ministry of Information in Great Britain announced recently that one hundred and two army Nursing Sisters have been killed under fire and that forty-four are missing in Malaya. Some are prisoners in Hong Kong, and nurses are also serving in seven major commands besides Malta, Gibraltar and Mauritius. Canadian casualties have been relatively light. Announcements to date show that three nursing sisters have died on active service.

The Rehabilitation Programme

Some time ago it was stated that the Canadian Nurses Association had made contacts with representatives of the United Nations Relief and Rehabilitation Committee, in order to assure them that the nurses of Canada are both ready and anxious to take part in the rehabilitation programme. Advice has now been received that a limited number of positions will be available to Canadian nurses who can qualify. Some of these will be expected to be ready at short notice. The requirements, both personal and professional, are high. Some interesting information regarding these has been made available.

In outlining the nature of the task it is suggested that the guiding purpose of the relief and rehabilitation programme is to help each country to help itself. This implies that appointments to nursing and other fields will be of a temporary nature. It is also suggested that personnel from other countries may be required to withdraw as soon as the people of the country concerned are able to carry on. It is emphasized that those assigned to duty in other lands must have a sympathetic understanding of and respect for the customs, conditions and values of the people among whom they work; that there must be no prejudices as to colour, race or creed. Co-operation is the keynote stressed. This includes co-operation with the authorities in the country in which the work is being carried on and with nursing organizations if these exist; if not,

it is suggested, their organization may be necessary.

Authorities have stated that nurses will be needed on different levels of experience. All levels call for high qualifications, both professional and otherwise. On all levels, at least a bachelor degree from a college or university of recognized standing, or its equivalent in experience, is required. Other qualifications suggested are: graduation from a school of nursing of high standing giving experience in the major services, including communicable diseases and preferably in such specialties as venereal diseases, tuberculosis, orthopedic and psychiatric nursing; the successful completion of at least one year of post-graduate study (more than this may be required for advanced positions), also experience in general hospital nursing plus experience on a supervisory or administrative level.

The ability to work well with other groups, especially in the public health and hospital field, and demonstration of ability to formulate plans and initiate programmes — these are some of the requirements suggested for nurses who are to serve with the rehabilitation programme in other countries. More specific information has been sent to the registered nurses association in each province.

British Civil Nursing Reserve

Nurses are still volunteering in limited numbers to serve with the British Civil Nursing Reserve and on the whole it is stated that Canadian nurses are giving excellent service. However, it is suggested with regret that lack of co-operation with British nursing authorities has been shown by a small minority. This may cause embarrassment and cast an unfortunate reflection upon Canadian nurses in general. The service is a voluntary one. The plan was set up to assist in relieving the burden being carried by the nurses in Great Britain and those applying are earnestly requested to consider this as the first objective to be reached.

A Gentleman's Agreement

It has been stated a number of times that nurses do not come under Selective Service regulations at the present time. However, in order to leave Canada, nurses are subject to the same regulations as any other citizens in Canada. When it comes to employment with American concerns operating in connection with the Alaskan Highway and its subsidiary projects, they are subject to the following agreement:

> United States employers in the Highway or labour projects will not engage Canadian nurses without the approval of our local offices, and, as a general rule, such approval is not given although *temporary* help may be provided to meet emergencies.

Canadian nurses are asked to avoid embarrassment and to seek employment in Canadian hospitals, where they are urgently needed.

Job Instruction

Have you read an excellent article by the Reverend Sister Mary Brigh entitled "We Cannot Afford to Hurry"? This appeared in the March 1944 issue of the *American Journal of Nursing* and reprints may be obtained from Mr. C. R. Dooley, Training Within Industry, War Manpower Commission, Washington, D.C. 25. It expresses an able nurse's opinion of "training within industry applied to nursing".

This article should be reviewed with Bulletin No. 5 entitled "Foremanship Training", published by the Department of Labour, Ottawa. Studied in relationship to nursing, "Job Training" is a new idea, but once the barrier of "men-

Data Regarding Schools of Nursing

Province	Total No. of Schools	Student Enrolment		Graduate Nurses		Bed Capacity (exclusive of Mental Hospitals)	
		Total	Graduating 1944	Head Nurses Supervisors	General Staff	Largest	Smallest
Alberta	11	956	293	175	139	485	75
British Columbia	7	1124	320	194	390	909	70
Manitoba	15	889	282	182	161	651	26
New Brunswick	13	531	171	124	88	400	42
Nova Scotia	15	712	205	170	65	310	50
Ontario	66	4024	1260	1294	1035	1113	42
Prince Edward Island	3	93	29	16	1	101	72
Quebec	34	2182	609	765	856	841	50
Saskatchewan	11	848	273	179	41	380	85

tal resistance", referred to by Sister Mary Brigh, has been broken down, it may be worth considering. Hospital and School of Nursing administrators should be particularly interested in looking into the possibilities. The registered nurses association in each province has been supplied with copies of both Sister Brigh's article and Bulletin No. 5.

Elsewhere in this issue of the *Journal* you will find an article by Miss Helen King giving her personal reaction to Job Instruction Training.

Data regarding Schools of Nursing

The accompanying table contains some interesting statistics compiled regarding approved schools of nursing in Canada as at February 1, 1944. The review of a comparative statement for 1939 shows that approximately 8,500 students were enrolled in 179 approved schools of nursing.

An Interesting Announcement

Some time ago there appeared in the *Nursing Times* an announcement that H.R.H. Princess Elizabeth had accepted the presidency of the Student Nurses' Association. More recent recognition of this interesting fact appeared in the Newsletter of the Wartime Activities of Women's Organizations in Great Britain. We have received permission to quote from this:

At a recent Council Meeting of the Royal College of Nursing, it was announced that Princess Elizabeth is to be first president of the Student Nurses' Association of the Royal College.

The Student Nurses' Association, with a membership of over 14,000 students in the various nurse training schools in Britain, provides a means whereby nurses from the outset of their professional lives may make their individual contribution to the community, which enables them to become more active and useful citizens and to co-operate more easily with their colleagues.

Since the outbreak of war, the Association's membership has doubled. In each hospital members form a self-governing unit, with a committee responsible for the general arrangements, finances and activities of the unit. A central representative council, composed of student nurses, and representative of the different types of hospital and training, unifies the work of the Association and provides a channel of communication with the Council of the Royal College of Nursing.

Not long ago some enquiries were received by the Canadian Nurses Association from New Zealand Registered Nurses Association, Inc., asking for information regarding the Student Nurses' Association of Canada. We had to admit that Canadian nurses have not yet sponsored such an organization. Is it a development worth considering?

Visitors to National Office

During the past month the Canadian Nurses Association has had welcome visits from Miss Anna Schwarzenberg, executive secretary of the International Council of Nurses; Miss Marie L. Johnson, assistant director of Nursing Bureau of the Metropolitan Life Insurance Company; Miss Mary Craig McGeachy, director, Welfare Division, United Nations Relief and Rehabilitation Administration, and Miss Lillian Johnston, Senior Public Health Nursing Officer, UNRRA.

M.A.R.N. Annual Meeting

On April 29, 1944, the registered nurses of Manitoba gathered at the Royal Alexandra Hotel, Winnipeg, for the thirtieth annual convention of the Manitoba Association of Registered Nurses. During the past few years the annual meeting has become a very important event in Manitoba, but in 1944 the honour and pleasure of being the hostess province for the Canadian biennial has quite overshadowed the local scene. On this account the provincial program was planned for one day only.

The meeting was opened by Miss, Adella McKee, president, and Mrs. Stuart Garson, wife of the Premier of Manitoba, gave a most friendly address of welcome. In her address the president spoke of the value of group effort, particularly during wartime. She reviewed briefly the important matters being considered by the Canadian Nurses Association, as well as the provincial association. It is of interest that three joint committees of the Manitoba Association of Registered Nurses and the Manitoba Hospital Association have been formed within the past few months to consider (a) the recommendations of the executive of the Canadian Nurses Association regarding salaries and working conditions for nurses; (b) clinical aspects of the nurses aide course, sponsored by the Nurses Association; (c) the question of shortage of nurses in the field of tuberculosis nursing and inadequate student nurse training in this clinical specialty.

The report of the executive secretary and registrar, outlining the expanding activities of the association office, was given by Miss Margaret Street, who succeeded Miss Gertrude Hall in this position in September, 1943. In her report as school of nursing adviser, Miss Street spoke of the necessity in wartime of maintaining standards of nursing education as a sound basis for meeting the increasing need for nursing service. The adviser outlined various projects undertaken in Manitoba as a means of safeguarding the education of the nurse. These included the work of the curriculum revision committee, the drafting of a plan for centralization of nursing education within the University, and the new university school for graduate nurses instituted during the past year and made possible by the federal grant to nursing in Canada. Mention was also made of the first year qualifying examinations for student nurses, which were implemented in Manitoba in June, 1942, "with the object of assuring a better definition and maintenance of standards, a greater uniformity in teaching and the opportunity to eliminate at an early stage pupil nurses who are unfit to proceed". Of the results of these tests Miss Street spoke as follows: "To date, 578 students have written these examinations of whom 25 or 4.3% have been disqualified. The percentage of failures is most conservative, yet there should be very few failures at all if candidates for admission to schools of

nursing could be selected with care from the point of view of background, personal and educational qualifications and general fitness for the profession of nursing."

The report of the assistant secretary included three main topics: the measures undertaken to stabilize nursing service in Manitoba; the administration of the government grant funds; and publicity and recruitment of student nurses. A year of constant activity, interesting projects and wartime undertakings was reported by the conveners of the three sections, and by representatives of the Graduate Nurses Associations from Brandon, Dauphin, Flin Flon, The Pas and Selkirk. Reports of standing committees also recorded a busy year. It is of interest that the Legislative Committee prepared a brief, concerned with the licensing and control of the subsidiary worker, for presentation to the Provincial Department of Health.

Miss Ina Broadfoot, convener of the arrangements committee for the biennial convention of the Canadian Nurses Association, reported on the plans now being made to make this an enjoyable meeting for all the visiting delegates. Miss Hazel Keeler, convener of the nursing reconstruction committee, outlined in her report plans for nursing education in the post-war period. She spoke of the thinking of the members of her committee regarding the development of a two-year and a four-year course for nurses. Reports of special projects included an account of a course for nurses' aides sponsored by the Association, as well as clinical postgraduate courses made possible by federal funds.

Miss E. A. Russell reported fully on the recommendations forwarded from Manitoba to the National Health Insurance Committee regarding health insurance and nursing service. These recommendations were the result of intensive study by section meetings, followed by a general meeting where suggestions and revisions were considered and final decisions agreed upon. Enlightening accounts of the activities of other groups were given by the M.A.R.N. representatives of the Council of Social Agencies, the Local Council of Women, the Canadian Youth Commission and the Committee on Epidemics.

An account of the work of the Winnipeg detachment, nursing auxiliary section, Canadian Red Cross Corps, given by the commandant, Mrs. Margaret Noble, revealed that hospitals and nurses are receiving most valuable assistance from volunteer workers, many of whom have full time positions in business offices during the day. Approximately 51,000 hours, or an average of 4,250 hours per month, have been given in hospitals by 443 V.A.D.'s enrolled in the detachment. This voluntary work on the part of the commandant, her assistants and the V.A.D.'s is deeply appreciated by this Association, as well as by the hospitals and other agencies who have benefitted by this excellent service.

After the morning session more than 80 nurses attended a delightful luncheon sponsored by the public health section when Miss Doris Saunders, dean of junior women, University of Manitoba, gave a most refreshing talk on the subject of "Our Contemporary Canadian Poets". This was enjoyed fully by a very responsive audience.

During the afternoon session Miss Hazel Keeler, director, School of Nursing Education, University of Manitoba, addressed the meeting. Under the title "Nursing trends in Canada" Miss Keeler spoke of the changing needs of nursing, and the trend toward the centralization of nursing education. She pointed out that nurses themselves must undertake responsibility for future developments within the nursing profession. "A true profession is a group of trained workers which has within itself the capacity for making a more and more specialized contribution to human welfare. The goal which we should set for ourselves is one toward which we will move more and more through our own initiative and resource."

Speaking on "Psychosomatic Medicine", Squadron Leader C. E. Stogdill, psychiatrist, R.C.A.F. Division, Deer Lodge Hospital, gave an extremely interesting description of the effects of emotional disturbances on physical health, tissue changes which take place, and the improved diagnosis and treatment of symptoms now made possible by advancing knowledge in this field of medicine.

In the evening over 100 nurses and a number of honoured guests assembled at attractive dinner tables gayly decorated with multicoloured may-poles which effectively illustrated the artistic skill and ability of Miss K. McLearn and the members of her social committee. All those present were intensely

interested in an address given by Mrs. Henrietta Laughran, director of the School of Nursing, University of Colorado, who chose as her subject "Interpreting Our Nursing Trends". Mrs. Laughran spoke essentially the United States. The Cadet Nurse Corps, of developments and trends in nursing in the growing use which is being made of the subsidiary worker, the growth and development of university schools of nursing, and the responsibilities which the well qualified nurse of the future will be called upon to assume were some of the highly vital and challenging topics discussed.

The nurses of Manitoba are now eagerly awaiting the date of the biennial convention when they will be happy to welcome nurses from the other provinces when they gather at the Fort Garry Hotel, Winnipeg, to discuss the many problems confronting the nursing profession in a world at war.

MARION E. BOTSFORD
Assistant Executive Secretary

R.N.A.P.Q. Annual Meeting

The twenty-fourth annual meeting of the Registered Nurses Association of the Province of Quebec which was held on May 15, 16 and 17, 1944, will go down in our history as one of, if not the most successful ever held by this Association, both from the point of view of general attendance and interest displayed. Apparently our members approved of the programme and the arrangements and were generous enough to take time out to say so. We are grateful for the encouragement and hope to go over the top next year, when, God willing, we may celebrate our silver jubilee.

The meetings were preceded on Sunday, May 14, by services of intercession and rededication, our French confrères attending the historical Bonsecours church in the early morning where special music and sermon were heard by hundreds of religious sisters and lay nurses. At 7 p.m. we attended evensong at Christ Church Cathedral where the newly appointed Dean, the Rev. Kenneth C. Evans, preached an inspiring sermon in which he generously commented upon the "missionary spirit" of the medical and nursing professions. Uniformed student nurses representing all the English language schools in the province preceded the choir during the singing of the processional hymn "Onward Christian Soldiers", while Nursing Sisters of the R.C.A.M.C., R.C.A.F., and the R.C.N.N.S., also in uniform, filed into their appointed places from the main entrance. The main body of the Cathedral, having been generously reserved for our use, was filled to overflowing. This service constituted our third annual memorial service, similar services being held simultaneously throughout the province.

The president, Miss Eileen C. Flanagan, presided at the opening session on the afternoon of Monday, May 15, which was bilingual and full of good business. The most important item was a thorough revision of the by-laws, and the adoption of by-laws by which the twelve district associations now in process of organization, will function.

Replacing the customary presidential address, Miss Flanagan reported upon the extensive two years activities of the Committee on Legislation of which she is chairman. These included the amendments to our Act and the revision of by-laws and provision for the necessary constitution and regulations which will make district organizations possible. Our legal adviser, Mr. Roger Ouimet, to whom much of the credit for the present Act is due, was present and paid tribute to the work of the Committee on Legislation and congratulated the Association upon our activities.

Reports covering the main general activities of our Association followed the meting adjourning in time to allow for preparations for the banquet which followed at 8.30 p.m. Five hundred and fifty-seven members and guests attended the banquet which was, in spite of war restrictions, a very delightful affair. The guest speakers were Miss M. Craig McGeachy, director, Welfare Division of UNRRA, and Miss Anna Schwarzen-

berg, executive secretary, I.C.N., both of whom were enthusiastically received and appreciated. Seated at the head table were the presidents of the Canadian Nurses Association, the Canadian Medical Association, the Canadian Hospital Council, the Canadian Federation of Business and Professional Women's Clubs, the provincial branches of Canadian Red Cross Society, St. John Ambulance Association, directors of religion, education and health departments, Junior League, I.O.D.E., together with the officers of the Association.

Meetings on the second and third day were conducted during the afternoons and evenings, the language groups separating to discuss and solve their respective problems and discharge their individual responsibilities. "Health Insurance and Nursing Service" and "The Role of the Nurse in a Programme of Venereal Disease Control" were the main topics at the meetings conducted in English, both being carried through the two days. "Venereal Disease Control" was presented by Lt.-Col. D. H. Williams, Chief, Division of Venereal Disease Control, D.P.N.H., Ottawa, on the second evening and at the round table discussion of the subject the third afternoon he assisted in a most generous manner. Our public health nurses will be grateful to Col. Williams for his guidance and advice.

Miss Esther M. Beith, director, Montreal Child Welfare Association and chairman, Committee on Health Insurance and Nursing Service, dealt with the health insurance idea on the afternoon of the second day, her address being "Nurses' Responsibility for Nursing Service under Health Insurance" and Miss K. W. Ellis, General Secretary, Canadian Nurses Association, on the evening of the third day, the title of her contribution being "Healthy Citizens — Canada's Greatest Asset".

Reports of section activities and other reports of special committees, together with a round table discussion on the proposed changes in registration examinations completed the English programmes, the discussion which accompanied all addresses and reports being the main outstanding feature of this particular annual meeting. For two whole afternoons and evenings the "floor" was occupied to an extent never before experienced in this part of the world — everything was thoroughly discussed and the scores of questions asked suggested that *"all's well"*. These sessions were arranged at hours convenient to the groups most interested, an experiment which proved to be very successful.

Our French-speaking members met in the afternoon of May 16 in the Hotel, and in the evening at Hôpital Notre-Dame, the attendance at the former being over 400 and the latter 700. The speakers in the afternoon were Dr. Emile Blain who spoke on "L'Infirmière en face de l'assurance-maladie" followed by discussion. This was followed by a presentation of "Le rôle de l'infirmière en service social, division des maladies vénériennes" by Mlle D. Letellier de St. Just, R.N., following which Mlle Alice Albert, travelling instructor and official visitor to French nursing schools, gave a progress report on district organizations.

At the evening session the topics included "Liberté ou Servitude" presented by M. Jean Pierre Houle, avocat, professor of history and geography at Stanislas College and "Rôle éducateur de l'infirmière en service social ou en hygiène publique" by Dr. M. Jules Gilbert, publicist, Provincial Department of Health. Miss Anna Schwarzenberg attended this session and in response to requests commented upon the things she had heard.

On Wednesday, the afternoon session was held in Hôtel-Dieu, the Canadian home of Jeanne Mance, who over 300 years ago as Canada's first nurse contributed a service of which our French-speaking nurses are justly and particularly proud and to whose memory that evening they paid due and grateful homage. The speakers in the afternoon were the Rev. Soeur Valérie de la Sagesse, French vice-president of the Association and director of nursing at Hôpital Ste. Justine, who took as her subject "Les auxiliaires dans le soin des malades" and Rev. Père Bernardin Verville who presented "Le sens social et la garde-malade".

At the close of the meeting the result of elections to the Committee of Management indicated that the members responded to the plant to increase the personnel of the Committee of Management from ten to fourteen members by electing five French-speaking and two English-speaking members, the Committee as a whole meeting two days later to elect their officers.

The personnel of the Committee of Management for the coming year is as follows: president, E. C. Flanagan; English vice-president, Mary Mathewson; French vice-president, Rev. Soeur Valérie de la Sagesse; honourary treasurer, Mary Ritchie; honourary secretary, Annonciade Martineau; members without office: Mabel K. Holt, Rev. Soeur Mance Décary, Marion E. Nash, Maria Roy, Ethel Cooke, Anne-Marie Robert, Rev. Sister M. Flavian, Marguerite Taschereau, Jeanne Lamothe; personnel advisory board: Margaret L. Moag, Vera Graham, Catherine M. Ferguson, Kathleen W. Ellis, Maria Beaumier, Juliette Trudel, Louise Taschereau.

E. FRANCES UPTON
Executive Secretary and Registrar

R.N.A.B.C. Annual Meeting

The thirty-second annual meeting of the Registered Nurses Association of British Columbia was held on April 14 and 15 in the Empress Hotel, Victoria. 117 nurses from near and distant points gathered to present and receive reports, to discuss problems and plans and to meet old friends.

The invocation opening the first meeting was given by the Reverend Hugh A. McLeod, D.D., of Victoria. In harmony with the trend toward greater co-operation between the medical and nursing professions, addresses of welcome were given by Dr. T. W. Walker, president of the British Columbia Hospitals Association and Dr. P. A. C. Cousland, President of the British Columbia Medical Association. Expressing concern at the apparent general unawareness of the rising costs of nursing education, Dr. Walker commented on the lack of government assistance in this essential field of education. Dr. Cousland emphasized the need for joint thinking and planning between the two associations, in the event of provincial and federal health insurance legislation.

In her presidential address, Miss Margaret Kerr reviewed the development of the Registered Nurses Association of British Columbia from 1912, when "the Vancouver Graduate Nurses Association, the Victoria Nurses Club and the New Westminster Graduate Nurses Association met for the purpose of organizing a new association which would unite the efforts of all nurses in securing governmental recognition and the legalization of registration for nurses in this province" to the present year, in which the outstanding event was the passing without amendment of a revision of the Registered Nurses' Act, in spite of considerable opposition. It was clearly shown how, as a result of undaunted enthusiasm and unstinting effort on the part of nursing pioneers and in the intervening years leaders with vision and determination, standards were achieved, developed and maintained. So great was the interest evidenced, that a resolution was drawn up directing that copies of the address be made available to all members.

The registrar drew attention to evidences of broadening of Association interests and influence and to the growth of Association membership. There were 444 new registrants during the fiscal year. 175 nurses availed themselves of the opportunity of practising nursing under the sponsorship of the Association by obtaining temporary war emergency permits. Twenty-one nurses received assistance through the Association's loan fund and Dominion Government Grant Bursaries. There has been a satisfactory increase in student enrolment in the seven schools of nursing and wartime problems are being ably met by school administrators and teaching staffs.

Miss McQuarrie reviewed the functions of the travelling instructor and emphasized institutes for the study of recent therapeutic and nursing advancements, for Job Instruction Training and Job Relations Training and other staff education projects.

In the first part of her report, the Director of Placement Service undertook to answer the following questions:

1. How may nurses enrol with Placement Service?
2. How many hospitals and other institutions list their vacancies?

3. What is done to assist a nurse in obtaining a position in a specified hospital?
4. How may employers of nurses help to improve the service?
5. How may nurses help to improve the service?
6. What does Placement Service wish to accomplish?
7. What are the limitations of the service?

With this background of organization and functioning, the year's developments and problems were reviewed. At all times there have been more general staff positions available than there has been nurses to fill them. Some nurses who enrolled for positions of administration, industrial nursing and office nursing, as well as some enrolled for part-time duty, have not found immediate employment. Most institutions report a rapid turnover in staff. In the Vancouver Regional Branch a monthly average of 129 nurses used the directory and in Victoria, an average of 70. There has been an increase in the total number of private duty calls received in both directories and although the number of nurses has not increased, the number of calls which have been filled has — showing a fine spirit of co-operation on the part of the private duty nurses.

On an attractive programme, the foregoing reports were grouped under a common heading — *taking stock*. Under *wheels in motion* were listed the reports of the Legislation, Press and Publications, Placement Service, Finance and Government Grant Committees. A new amendment to the by-laws makes provision for an arrangements committee distinct from the programme committee. The successful activities of the press and publications committee, under the energetic chairmanship of Miss Janie Jamieson, has resulted in an increase of subscribers to *The Canadian Nurse* of 374 or 52% since November.

Following this session, the meeting adjourned to the Princess Louise Room, where a tea was held in honour of the president. This was the Association's farewell to Miss Kerr and a token of appreciation for her long and very active years on the Council.

Under *pooling nurse power*, came the reports of the Sections. The Hospital and School of Nursing Section reported a study of relationships between regular hospital staffs on one hand and the temporary graduate nurses, the volunteer and paid nursing aides on the other. The convener of the Public Health Section outlined the expansion in public health nursing services. The General Nursing Section went on record as favouring a wider use of staff conferences as a means of keeping all the nurses informed not only on matters related to actual hospital affairs but also on matters of particular concern to nurses generally. A panel discussion — *pulling together* — was enlivened by skits portraying the right and wrong ways of orienting professional and non-professional nursing staff members.

The theme for the morning session Saturday was *balancing the load*. Miss Mallory, convener of the committee on districts and chapters, outlined the functions of this committee and described the *manual of information for districts and chapters* which is in preparation. The reports of the districts indicated much worthwhile activity on the part of the component chapters. Two districts have experienced great difficulty in arranging for meetings, because of the difficulties of travelling. Miss Margaret Duffield summarized the information received through a questionnaire on hours of duty, salaries, sick leave, etc., that had been sent to all hospitals in the province and Miss Margaret Motherwell gave a report on recommended salary schedules and conditions of employment. Miss Mary Campbell, convener of the Labour Relations Committee, reviewed the events which initiated the formation of this committee and the winter's activities. The latter have consisted mainly of seeking and studying available material and consulting with other professional and non-professional groups.

In the final session — *the road ahead* — the report of the Health Insurance Committee was presented. The convener made an urgent plea to nurses to study the problems for nurses which health insurance may create. An address by Dr. Dorothy Mawdsley, Dean of Women at the University of British Columbia — Women in the reconstruction programme — proved both stimulating and informative and was thoroughly enjoyed by everyone.

ALICE L. WRIGHT
Registrar.

Overseas Mail

On the Italian Front

The following excerpts are taken from a letter received recently from Principal Matron Blanche Herman:

We are learning something new each day in the treatment of wounds — we have had some very interesting cases treated with Penicillin, and now we are faced with the various tropical diseases, typhus and malaria.

The hospital is fairly busy — no doubt before long we shall be busier still. In order to relieve the pressure on the wards and to add more beds to our establishment we have started using tents. One Charge Sister is responsible for three or four tents, each tent holding thirty patients. It amazes us to find how well we can manage with the few things available. The Sisters and orderlies are most ingenious in the things they make and the other day I was quite amused with a gadget I saw on one of the wards. One of our burned cases could not raise his arms and loved to smoke frequently, so they designed a holder which resembles a child's toy gun — the trigger being wire with a loop on the end of the stick to hold the cigarette; it worked well and he seemed very happy.

We have a rest home for the Sisters on the Adriatic coast. In this country there is no system of periodic leaves such was in effect in Britain so I send those who are looking tired and who need a good rest. They return looking fit and ready for work. We plan on wearing khaki on duty. It is much more practical when considering living conditions, and laundry facilites. Shortly we shall be wearing the anti-mosquito clothing at night. The flowers are in bloom, the almond and cherry trees in blossom — a very lovely sight with the mountains in the background. A short time ago Mount Vesuvius was very active. It was the most fascinating spectacle I have ever seen and one not soon to be forgotten. The molten lava would burst forth with a volcanic sound, then pour down the side of the mountain like a slowly moving stream.

We have periodic visits from our friends in England among them General Crerar and General Alexander and last Sunday, General Vannier paid us a long visit. We try to see as much of the country as possible and the Sisters have a car at their disposal each afternoon which enables them to get about. Visits to the Isle of Capri were made shortly after we landed in this country — a delightful spot.

And here is a friendly message from Sec. Lieut. M. W. Bennett of the American Army Nurse Corps:

Though I am a Canadian nurse serving with the United States Army Nurse Corps, I am still very interested in what is going on in the Canadian nursing world especially since my training school was the Montreal General Hospital. The M.G.H. unit is located only a few miles from us and I hope to be able to visit their hospital at some future date.

Prince Edward Island is always represented when a tough bit of work needs doing and here is a cheery word from Nursing Sister Margaret MacEachern, of Charlottetown:

We came to Italy some time ago and each ward in our hospital has between one hundred and twenty and a hundred and forty beds. The ward is divided into six sections of twenty or more beds. These sections are particularly useful on the medical wards for the purpose of segregation.

We are living and working in comfortable, clean buildings, with running water and electricity. Of course, the water is cold, and you sometimes find it running in the most unexpected places. The lights go out when you least expect it, but that is part of the fun. Water for washing is heated out-of-doors, and for compresses and the like we use a primus stove, and any kind of suitable container that is available. We have visited several interesting places; Naples, Pompeii, Sorrento and Capri were the most popular. The scenery is most beautiful but the destruction, filth and poverty are nothing short of appalling. On any main street you will see crowds of dirty, barefoot children begging for cigarettes, candy, biscuits, money or

anything else they can think of. We are wearing battle dress, with slacks for duty, and khaki skirts for off-duty wear. Our meals are excellent with plenty of fresh fruit and nuts available. In fact, life is very good indeed.

On Duty in India

The following message has been received from Lt. Claire Robillard, A.N.C. Her good wishes are heartily reciprocated:

I have been with the U. S. Army Nurse Corps in India for over a year now and enjoy reading any articles concerning nursing activities at home. I still consider Montreal my home having trained there and I am still a member of the R.N.A.P.Q.

Our work here is of utmost interest, as we have familiarized ourselves to some extent with all kinds of tropical diseases and their complications. Our stock of knowledge and experiences will naturally grow as time goes on.

Our best wishes to *The Canadian Nurse* from India.

War Nurseries

The term "war-nursery" is used to describe resident homes for young children who have lost their homes as a result of air raids, as well as day-homes for children of pre-school age whose mothers are engaged in war-time occupations. There are in addition special institutions which have been set up in devastated areas for the benefit of children of all ages. The first of these war-nurseries was organized in Great Britain by the Women's Voluntary Service and consist of country cottages accommodating some 40 or 50 children under 5 years of age in charge of a qualified matron. They are now being operated by the Ministry of Public Health, with the continued co-operation of voluntary helpers. The Junior Red Cross of the United States, Canada, and Great Britain all have a notable place in this work. The Canadian Junior Red Cross, beginning with eight, has now undertaken to contribute towards the support of 14 of these nurseries.

This comes from a director of a country nursery:

All the children at this nursery are from London and most of them have had very unpleasant experiences. We thought they had forgotten about the raids, but last week we were proved wrong. All the children were upstairs when there was a sudden terrific clap of thunder. With one accord the children all shouted "bombs" and rushed for the stairs and came helter-skelter down to the ground floor. For a few minutes matron had a small riot on her hands. It was difficult to explain to such tiny children what thunder was, and that although it sounded like bombs it wouldn't hurt them. What impressed me was not that they should remember the horror of the raids but that they should remember instantly that they must go downstairs for safety. Of course they are not frightened all the time — only at sudden noises — and in fact I know from personal experience they play at "air raids" when they are alone. I was outside one of the dormitories and I heard one of them make a noise reminiscent of a siren; then a little voice said: "I'll just go up and see if my house is still standing" and then "Yes, it is still there". They were, in imagination, living in their Anderson shelter during a raid.

A similar enterprise for the benefit of French children in devastated areas is that known as "Maisons des Petits Français". The project was started by a group in Switzerland, touched by the plight of large numbers of children lost and abandoned as a result of evacuations. They are collapsible wooden houses, provided with every convenience and

capable of accommodating 50 children. The Swiss children wrote a letter of greeting to the French children which was framed and placed in the refectory and each house bore the arms of Switzerland and of the Canton and the Red Cross emblem.

Although these nursery schools have been started as a war-time measure, the kind of life led by the children who frequent them is calculated to be of permanent value to them, for in practically every case they are under the direction of experienced child welfare workers with trained staffs who endeavour to inculcate in the children healthy habits and good social attitudes.

—*League of Red Cross Societies*

McGill University Announces Bachelor of Nursing Course

The Governors of McGill University announce that, beginning next session, a two-year course of study leading to the degree of Bachelor of Nursing will be offered in the School for Graduate Nurses. The present one-year certificate courses and the four-month programmes will be continued while the need for them exists. Eligibility for the new course will be determined on the basis of good health, a suitable personality, educational qualifications, and professional experience in which the candidate has demonstrated capacity and special ability.

In the first year, under the new two-year plan, students will take a general course of selected subjects in the Faculty of Arts and Science, the Faculty of Medicine, and in the professional field. The second year programme will consist of nursing and allied subjects, closely correlated with observation and practice in the following major fields: Teaching and Supervision in Schools of Nursing; Public Health Nursing; Administration in Schools of Nursing; Administration in Public Health Nursing.

The entrance requirements for all students are as follows:

General education: Senior Matriculation, or its equivalent, the required subjects being English, Chemistry, and three of the following: History, Biology, French, German, Spanish, Latin, Mathematics, Physics.

Professional education: Graduation from an approved school of nursing, with a creditable record in theory and practice.

Experience following graduation: (a) for specialization in Teaching and Supervision in Schools of Nursing, and in Public Health Nursing, at least one year of satisfactory experience; (b) for the courses in Administration in Schools of Nursing, and Administration in Public Health Nursing, at least three years of satisfactory experience in which executive ability has been demonstrated.

Application forms and further particulars may be secured from the School for Graduate Nurses, 3466 University St., Montreal.

Obituaries

The passing of the **Rev. Sister Mary Casey, S.G.M., R.N.,** Mother Provincial of Alberta, at Edmonton on May 2, 1944, marks another milestone in the history of nursing.

Sister Mary Casey, a graduate of Notre Dame Hospital, Montreal, came west in 1898, and in 1908 established the school of nursing of the General Hospital at Edmonton. For many years she remained as superintendent of nurses of that institution. The foundation of this new large school of nursing and the fact that she spent over thirty years here makes her one of the pioneers of nursing in the Province of Alberta. Her death, coming at a time when the centennial of the Grey Nuns service in Western Canada is being celebrated, is to be regretted.

STUDENT NURSES PAGE

The Nursing Care of Scalds

DOREEN GRANT

Student Nurse

Charlottetown Hospital, P.E.I.

Colin is 27 months old and is the second youngest in a family of five. He is a very bright child with clear, clean skin and has the appearance of being well cared for. His parents are intelligent, hard-working people who make the most of their modest resources to provide the best care for their growing family. Colin had never been ill and had no previous experience with doctors, nurses or hospitals.

The morning of the day on which he was admitted to our hospital he had suffered a severe scald by tipping over a partially filled tub of boiling water. He was treated by a doctor at home with gentian violet and taken by car to the hospital, a distance of about twenty miles. On admission, he showed mild shock. He was very pale and his skin was cold. The pulse rate was 100 and of fair volume. The whole posterior part of both arms, the upper part of both thighs, the genitals, and the whole right side of the chest and abdomen were completely denuded of skin with first and second degree scald burns. He was taken to a warm room and given one-sixth of a grain of morphine hypodermically. Then the entire burned areas, excepting the genitals, were covered with sulphamul impregnated mesh gauze, white swan waste, and compression bandages of flannel. Sulphamul was applied freely to the genitals, which were left uncovered. He was then wrapped in warm woollens and placed in a heat tent, arranged by placing a frame, to which several electric light bulbs were attached, over his crib.

After 48 hours he was removed from the heat tent and his general condition was considered satisfactory. He was taking fluids freely. Milk, which he took through a bent tube, was his favourite. We realized that now a great deal depended on the nursing care. The chief problem was to keep his dressings clean and dry and thus prevent any infection of the wounds. Although he probably had been trained in toilet habits the change of environment made it difficult for him to avoid involuntary defecation and micturition. It was necessary to change him very frequently during the first weeks but gradually he did learn to call his nurse when he wanted to urinate. Cellophane was used around the lower dressings in an effort to keep them dry and thus contamination by urine and feces was only very slight.

One week after admission the dressings were removed by the doctor who wore sterile gloves and gown as he did also for the first dressing and for subsequent ones. Healing showed good pro-

gress with very little discharge. The same type of dressings were reapplied and once weekly the dressings were changed. The changing of dressings did not present any great problem as Colin liked to have it done and it was never necessary to administer any sedative as it did not cause him great pain. In three weeks the arms, legs and genitals were completely healed. There was a large denuded area extending around the right abdomen to the right flank, with only a few small islands present, so it was decided to do a skin graft to facilitate healing. Under general anaesthetic, multiple pinch grafts from the left side of the abdomen were placed over the denuded areas and dressings applied as before. One week later, when the dressings were removed, it was found that some of the islands had died but enough were present to hasten the healing process considerably. On his discharge from the hospital, there was still an area, about 15 cm. in diameter, not healed. For a short time Colin returned weekly for dressings. Then it was thought advisable for his mother to carry on at home as healing was quite satisfactory.

The urine was checked every other day for the first ten days and then once weekly but at no time did it show any abnormalities. His blood picture on admission showed R.B.C. 6,200,000; W.B.C. 40,000; hemoglobin 95%. Three weeks following, R.B.C. 3,780,000; W.B.C. 12,000; hemoglobin 75%.

From the study of this case I learned something of the nature of burns and their treatment. From watching the doctor change the dressings I learned the necessity of aseptic technique in treating wounds. I learned the probable complications of burns and what symptoms to watch for and report. I learned too that even a very young child will respond to kind treatment and gentle handling and the advantages of such response to the nurse.

Scholarships in Public Health Nursing

The Quebec Provincial Division of the Canadian Red Cross offers Scholarships of the value of $500 each to graduates of approved schools of nursing in order that they may take the course in Public Health Nursing in any one of the Schools for Graduate Nurses conducted under the auspices of the Universities of the Province of Quebec.

Essential Qualifications

1. The candidate must produce a letter from the Director of the School of her choice stating that she has met all the requirements of the University for admission to the course in Public Health Nursing.
2. She must possess a strong physique and good health.
3. She must give proof of personal aptitudes for community service.
4. She must furnish certificate of University Junior Matriculation or Provincial High School Leaving certificate (Grade XI) with an average of 60%.
5. She must be willing to sign a contract to serve, under salary, in a Red Cross Nursing Outpost or in a Public Health Field designated by the Red Cross for a period of two years immediately following upon graduation from the University training.

Desirable Qualifications

1. Previous graduate nursing experience under supervision.
2. Bilingualism.

Address all enquiries to The Commissioner, The Canadian Red Cross Society, Quebec Provincial Division, 3416 McTavish St., Montreal.

Pardon my yawn nurse, it's that soothing Z.B.T. powder!

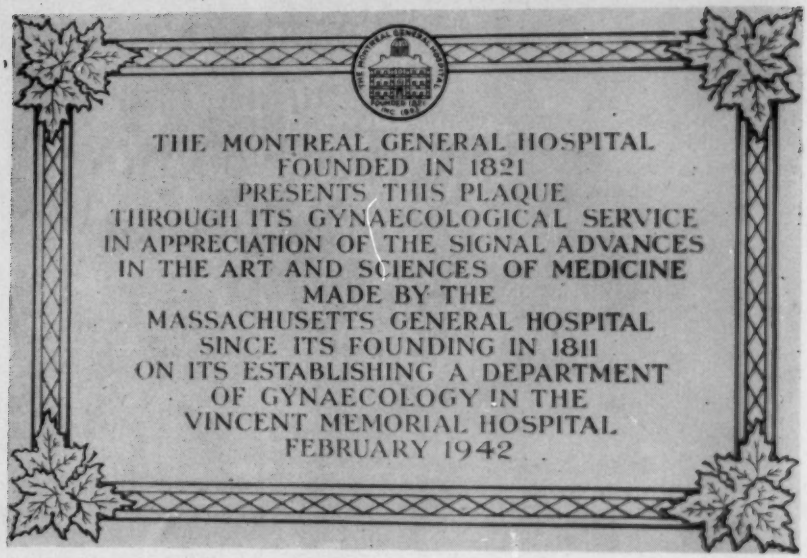
YOU'LL see what baby means, nurse, when you rub a little Z.B.T. Baby Powder between your fingers. Feel its downy-soft, superior "slip". That smooth slide tells you how Z.B.T. Baby Powder acts in tender skin folds.

Z.B.T. Powder with Olive Oil is long-clinging, moisture resistant—advantages that add greatly to baby's comfort. For they mean better protection against wet diapers and perspiration.

Make this convincing test with Z.B.T. containing Olive Oil

Smooth Z.B.T. on your palm. Sprinkle water on it. See how the powder doesn't become caked or pasty. The water doesn't penetrate it, but forms tiny powder-coated drops—leaving the skin dry and protected. Compare with other leading baby powders.

One "M.G.H." Salutes Another


THE MONTREAL GENERAL HOSPITAL
FOUNDED IN 1821
PRESENTS THIS PLAQUE
THROUGH ITS GYNAECOLOGICAL SERVICE
IN APPRECIATION OF THE SIGNAL ADVANCES
IN THE ART AND SCIENCES OF MEDICINE
MADE BY THE
MASSACHUSETTS GENERAL HOSPITAL
SINCE ITS FOUNDING IN 1811
ON ITS ESTABLISHING A DEPARTMENT
OF GYNAECOLOGY IN THE
VINCENT MEMORIAL HOSPITAL
FEBRUARY 1942

International scientific appreciation and camaraderie are illustrated in a plaque bordered with Canada's maple leaves, presented by The Montreal General Hospital to mark the establishment of a department of gynecology made possible when the Vincent Memorial Hospital "moved in" with the Massachusetts General Hospital. Dr. Archibald D. Campbell, chief of the gynecological service at The Montreal General Hospital, made the presentation, and Mr. Henry C. Everett, president of the Vincent Memorial Hospital and Dr. N. W. Faxon, director of the Massachusetts General Hospital, accepted the gift. The following excerpts are taken from the text of the address delivered by Dr. Campbell on that historic occasion:

On behalf of The Montreal General Hospital, let me thank you for the privilege of meeting the trustees of this — another M.G.H. There is a particular parallelism in the history of these two institutions. They were the first hospital and for years the only English hospital in their respective seaport cities. Now, both mellow with age, enriched by the experience of a century, they are steeped in similar traditions. Your hospital was founded in 1811, while The Montreal General Hospital was founded ten years later; both opened their doors for the reception of patients in 1821.

Your great men of other days, such as Shattock, Warren, Oliver Wendell Holmes, William Morton, Cabot, Cushing, outstanding in their time, still live. Of the Shattock lecture of The Massachusetts Medical Society in 1892, Sir William Osler remarked, "While the president was anointing the orator, looking over the 1200 men in the big Mechanics Hall, I received a definite impression that never had I seen so large a collection of doctors with faces indicating breeding and pasture".

While the remarks of Osler were true, they were also prophetic. In establishing a department in Gynaecology in the Vincent Memorial Hospital for the treatment of diseases peculiar to women, the Massachusetts General Hospital is now enlarging that pasture. The present incumbents will see to it that new laurels are added to this great institution, in the corridors of which one is

conscious of noble traditions, of high purpose and great achievement.

It is true that there is a line which divides our countries but this, to our great good fortune has always been more apparent than real and may it even continue to become less discernible. There should be no dividing line between freedom-loving peoples. If we are to keep faith with those who built those traditions and with those who today have gone forth as crusaders in their defence, a stout link must be forged between all worthy institutions. Though the seeds of suspicion and antagonism have been sown by those intent on our destruction, it is nevertheless a propitious time to plant the roots of peace by forging lasting bonds of freedom and unity.

Book Reviews

Safe Convoy, by William J. Carrington, A.B., M.D., F.A.C.S. 256 pages. Published by Longmans, Green & Co., 215 Victoria Street, Toronto 2, Canada. 1944. Price $3.

Today, with birth rates rising in every part of the country and with available medical and nursing staffs very considerably reduced, a book which can supplement the prenatal instructions which are given is indeed a find. The apt title confirms the premise on which Dr. Carrington has built his material: "Human beings fear the unknown". "Knowledge is the antidote of fear". Conservative estimates indicate that one-fourth of all maternal deaths occur in women who are totally unfit subjects for childbearing. If danger lies ahead, a woman and her husband are entitled to all of the facts.

In simple language, which never loses its piquancy and verve, dozens of bugaboos that haunt the young mother are laid at rest. Carefully, she is steered through the various factors which contribute to sensible living during pregnancy; she is warned of the minor ailments which may occur and simple preventive measures which she might take. For example, in discussing heart burn, Dr. Carrington suggests, "Rich indigestible food, overeating or improper mastication may be the cause. A simple preventive is a tablespoonful of cream swallowed one-half hour before meals. Cream taken with meals aggravates heart burn, but if taken half an

University of Toronto School of Nursing

For the session 1944-45 the following courses are offered:

A. The Degree course in Nursing, B.Sc.N., 4 years in length.

B. The Diploma course in Nursing, 39 months in length.

These basic professional courses (i.e. A and B) carry a qualification for staff work in both hospital nursing and public health nursing. While it has been announced previously that a professional certificate would be added to the Degree to indicate that the graduate of this course has certain special professional standing, it has been decided that the purposes of nursing education will be served better if the certificate is not added: thus the value of the Degree itself will be enhanced.

NOTE: These courses will prepare students for registration under the Nurse Registration Act of the Province of Ontario.

C. Diploma courses, 2 years in length, for graduate nurses:

1. Nursing Education.
2. Public Health Nursing.

D. Certificate courses, 1 year in length, for graduate nurses:

1. Clinical Supervision.
2. Hospital Administration.
3. Nursing Education.
4. Public Health Nursing.
5 Advanced Studies.

N.B. Attention is drawn to the fact that the Certificate courses in Public Health Nursing as offered to graduate nurses (see C and D above) will start this year in August instead of September. These courses are being accelerated in order that the students will be ready for the field at an earlier date than usual in the spring.

For further information address:

The Secretary
School of Nursing
University of Toronto

THE UNIVERSITY OF WESTERN ONTARIO

Division of Study for Graduate Nurses offers the following courses:

A five-year course leading to the degree of Bachelor of Science in Nursing.

Courses covering one academic year and leading to certificates in:

1. **PUBLIC HEALTH NURSING**
2. **INSTRUCTOR IN NURSING**
   (Teaching and Supervision in Schools of Nursing)
3. **HOSPITAL ADMINISTRATION**

For information apply to:

Division of Study for Graduate Nurses
Faculty and Institute of Public Health
London - Canada

University of Alberta

SCHOOL OF NURSING

COURSES FOR GRADUATE NURSES

1. Diploma in **Public Health Nursing** consisting of one academic year.

2. With the addition of an extra year of required courses, the student may obtain a **Bachelor of Science** degree in **Nursing.**

3. An Advanced Course in **Practical Obstetrics** for **District Nurses** of three months' duration, planned to provide instruction and clinical experience in antepartum, delivery, and postpartum care of pregnant women.

For information apply to:

School of Nursing
University of Alberta
Edmonton, Alta.

hour beforehand it suppresses the secretion of acid".

To the young mother who worries over the possibility of giving birth to a deformed child, Dr. Carrington brings assurance. "The chances are exceedingly remote, because the great majority of abnormalities end in spontaneous abortion during the early months of pregnancy. If the fetus remains in the uterus beyond four months, the odds are 200 to 1 that the child will be born without the slightest blemish".

The more serious complications of pregnancy are noted without any undue emphasis. Perhaps greater stress could have been placed on the early discovery of syphilis and the fact that, with adequate treatment prior to the fifth month of pregnancy, prenatal syphilis in the newborn infant will be obviated. The value of hospitalization vs. home care is clearly explained; how the various stages of labour progress; the puerperium; care of the newborn infant; and a final chapter on fathercraft.

The material is authentic, clear and persuasive. There are enough humorous bits to relieve any worries the nurse might have of giving a scientific study to a patient. This book will be a valuable addition to the library of every public health nurse and to all others interested in securing "Safe Convoy" for Canada's young mothers.

Virus Diseases in Man, Animal and Plant, by Gustav Seiffert, translated by Marion Lee Taylor, Ph.D. 332 pages. Published by the Philosophical Library, Inc., 15 East Fortieth Street, New York, N.Y. 1944. Price $5.00.

This material was published upon recommendation of the National Research Council and, while much of it is obviously beyond the grasp of the average nurse, those who want to become more familiar with this very wide field will find this collection of data from varied reports useful. Since such a wide variety of common communicable diseases have their origin in the filterable vira, there are sections dealing with such familiar conditions as common cold, mumps, encephalitis, acute rheumatic fever, etc. These would be of interest particularly to nurse instructors.

Essentials of Dermatology, by Norman Tobias, M.D. 497 pages. Published by the J. B. Lippincott Company; Canadian Office: Medical Arts Buildings, Montreal. Second edition, 1944. Price $5.75.

A simplified form of a very important topic is always welcomed. Knowledge of the various forms of diseases of the skin is expanding rapidly and nurses must keep themselves informed. While this book is intended primarily for the general practitioner and the medical student, it is well worth including as a reference text in the libraries of schools of nursing. Public health nurses in particular, who see the patients at home, in industry or at school, would benefit by having access to a text of this kind.

There are numerous photographs to illustrate the various conditions described. As well as describing the clinical appearance of the various diseases, Dr. Tobias outlines the etiology, diagnosis, differential diagnosis, course and treatment.

Victorian Order of Nurses

The following are the staff appointments to, transfers, and resignations from the Victorian Order of Nurses for Canada:

Winnifred Tredaway and *Helen Voss,* who stayed on the Montreal staff following a two months' period of supervision and experience introductory to Victorian Order nursing, have been posted to Edmonton and Pictou respectively.

Mrs. Faulkner (*Marion DeLong*) has been transferred from the Halifax staff to the Saint John staff.

Margaret Graham, B.Sc.N., has been transferred from the Edmonton staff to be nurse-in-charge of the Saskatoon Branch.

Doris Kirkwood has resigned from the Galt staff where she had been temporarily employed.

Catharine Small has resigned from the Montreal staff to be married.

Mrs. Dorothy Harrison, who has been in charge of the Saskatoon Branch for the past year and a half, has resigned and is leaving Saskatoon to be with her husband.

Helen Bradley has resigned from the Regina staff to enter the R.C.A.M.C. Nursing Service.

McGILL UNIVERSITY SCHOOL FOR GRADUATE NURSES

The following one-year certificate courses are offered to graduate nurses:

TEACHING AND SUPERVISION IN SCHOOLS OF NURSING
PUBLIC HEALTH NURSING
ADMINISTRATION IN SCHOOLS OF NURSING
ADMINISTRATION AND SUPERVISION IN PUBLIC HEALTH NURSING

As a war measure, two four-months programmes are offered:

CLINICAL TEACHING AND SUPERVISION
ADMINISTRATION AND SUPERVISION IN PUBLIC HEALTH NURSING

For information apply to:

School for Graduate Nurses
McGill University, Montreal.

UNIVERSITY OF MANITOBA

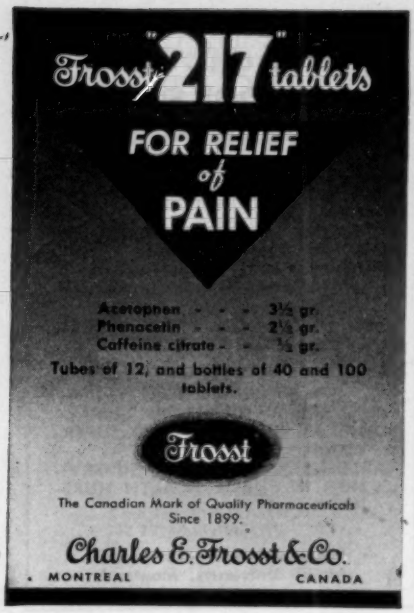
Post Graduate Courses for Nurses

The following one-year certificate courses are offered in:

1. **PUBLIC HEALTH NURSING**
2. **TEACHING AND SUPERVISION IN SCHOOLS OF NURSING**
3. **ADMINISTRATION IN SCHOOLS OF NURSING**

For information apply to:

Director
School of Nursing Education
University of Manitoba
Winnipeg, Man.



NEWS NOTES

ALBERTA

EDMONTON:

Royal Alexandra Hospital:

The Royal Alexandra Hospital Alumnae Association met recently, with the president, Miss V. Chapman, in the chair. Thirty-two dollars was donated to the Red Cross Prisoner-of-War Parcel Fund, which was half the proceeds of a recent dance. A draw for a needlepoint stool was held recently with Miss Lennie McNeil, past president of the Edmonton Soroptomist Club, making the draw. The proceeds will go toward the Alumnae Scholarship Fund. Miss Eva Sangster gave a most helpful and informative talk on how to budget.

BRITISH COLUMBIA

CHILLIWACK:

In her presidential address at the third annual meeting of the Chilliwack Chapter, R.N.A.B.C., Dorothy Priestly emphasized the importance of each member identifying herself with one of the three sections. Mrs. C. S. Pennock, secretary, reported a growing membership and interest. During this past year contributions were made to the British Nurses Relief Fund, China Relief and the Red Cross. Parcels were sent to Nursing Sisters overseas.

The following officers were elected: president, Dorothy Priestly; vice-president, A. McKay; secretary, Mrs. C. Pennock; treasurer, Miss Baptist; committee conveners: hospital and school nursing, K. Crowley; general nursing, E. Morton; public health, G. Starke; program, Mmes C. Melville, Hatfield; refreshments, Mrs. F. C. Storey, Miss Sloan; visiting, Mrs. W. Stevenson; membership, Miss Dobbie, Mmes J. Barker, J. Kirkness, Gregg; finance, Mrs. Robb; representatives to: press, Mrs. J. D. Munroe; *The Canadian Nurse*, L. Hodgkins.

KAMLOOPS:

The Kamloops-Tranquille Chapter, R.N.A.B.C., has decided to establish a scholarship. Efforts to raise sufficient funds will be made during the coming year. It is hoped that this will be made a community effort as it will be offered to a graduate of the Royal Inland Hospital training school.

The Chapter recently held a Valentine Tea at the nurses home of the Royal Inland Hospital. The large tea-table was covered with a lace cloth and Valentine motifs, while tulips, daffodils and coloured candles added much to the decorations. Several

booths added to the attractions such as the "white elephant" booth attended by Mrs. S. Dalgleish and Peggy Crowe and the popular apron table at which Mrs. Hopgood and Mrs. Hinds were kept busy. The music rendered by Gertrude Reid and Dorothy Hopgood was much appreciated. A cut-work table-cloth donated by Mrs. H. D. Haywood was raffled for $125, $25 of this being voted for Red Cross purposes and $25 to the Prisoners of War fund. Net proceeds for the tea and raffle were $218.57.

Study groups were held by the Kamloops-Tranquille Chapter during the past year on the following subjects: Dominion Registration, Dominion Health Insurance, the proposed Amendment to the Nurses Act.

NOVA SCOTIA

New Glasgow:

The Florence Nightingale Memorial Service was held recently at the First Presbyterian Church, when the Rev. Lloyd MacLellan was the speaker. About 90 nurses, including students of Aberdeen Hospital, and graduates of Pictou County, attended in a body.

The Aberdeen Hospital Alumnae Association met recently at the home of the president, Mrs. MacG. MacLeod. A "Grab Bag" sale was featured and was very successful, serving to augment our funds. Plans were made for a picnic meeting to be held at Pictou Landing in July.

Lenora MacMillan, president of the Pictou County Branch, R.N.A.N.S., Mrs. Wilfred Burchill, councillor, and Mary Ross, delegate attended the two-day session of the 35th annual convention of the R.N.A.N.S.

ONTARIO

Editors' Note: District officers of the Registered Nurses Association may obtain information regarding the publication of news items by writing to the Provincial Convener of Publications, Miss Irene Weirs, Department of Public Health, City Hall, Fort William.

Districts 2 and 3

At the regular meeting held in Woodstock recently the reports of sections showed increased interest, but the same old cry of unanswered letters was raised; this was felt to be a drawback to the completeness of reports and we were urged to be more careful and thoughtful in future. The guest speaker of the afternoon was Dr. Lois Kent, Ontario Hospital, Woodstock, recently returned from the mission fields of India. Section meetings were held under the leadership of each representative. At the combined meeting which followed some desired results were achieved in that those working in each section had had a chance to meet others and

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it is hoped this will be a usual procedure at future meetings. Mr. Karl Kitching, Woodstock Collegiate Institute, was speaker after supper on "How *far* is an hour".

The spring meeting of the public health section was held in Kitchener recently. Short papers on the visiting nurse and the nurse in industry, the public health nurse and the nurse in industry, and the industrial nurse and what co-operation is desired from other public health nurses were presented. The guest speaker was Miss Ward of Toronto.

District 5

A large group of nurses attended the May meeting held in Toronto when student nurses of hospital training schools in the district were special guests. Miss P. Morrison, the president, was in the chair and gave a most interesting report of the recent R.N.A.O. convention in London. The programs took the form of a quiz contest for students and graduates: Miss S. Sewell was a capable and entertaining master of ceremonies, and the questions, humourous and otherwise, dealt with nursing problems and personalities. By a narrow margin the student team won the contest, and each member of it was presented with a clinical thermometer. Refreshments were served at the close of the evening by the entertainment committee.

Toronto:

At two impressive gatherings recently some 1400 nurses of the Toronto district took part in National Memorial and Rededication Services sponsored by the Canadian Nurses Association and the Overseas Nursing Sisters Association. At Yorkminster Baptist Church, where 800 Protestant nurses assembled, a beautiful recital of organ music by Mr. D'Alton McLaughlin preceded the main service. Students from various hospital training schools together with the graduate nurses occupied the centre seats. The minister, Dr. W. A. Cameron, conducted the service and chose as his topic "Sidestepping or Serving". Roman Catholic nurses met in St. Michael's Cathedral, where the boys' choir provided fine music under the direction of Father Ronan. The Archbiship of Toronto, the Most Reverend J. C. McGuigan, attended the service which was conducted by Rev. A. E. McQuillan, with Rev. A. J. Belanger preaching the sermon. Approximately 600 nurses attended, including Sisters from St. Michael's, St. Joseph's and Our Lady of Mercy Hospitals.

District 7

The annual meeting of District 7 was held recently. The guest speaker for the evening was Dr. Duncan Boucher who spoke on the treatment of burns. District 7 is very sorry to lose Isabel Black who is leaving to take a position with the Department of Health,

Toronto. Miss Black has been in charge of the V.O.N. work in Kingston for the past three years and will be greatly missed both on and off duty. Florence Latimer has returned to the teaching staff at the Ontario Hospital, Kingston, after spending the past year in postgraduate work at the University of Toronto School of Nursing.

A meeting of the Kingston Chapter was held at the Ontario Hospital and John Houck, M.A., psychologist at the Mental Hygiene Clinic, spoke on child delinquency. Nurses rededication services were held recently at St. Mary's Cathedral and St. Paul's Anglican Church in Kingston.

The officers for the coming year were elected by District 7 as follows: chairman, Ella G. Smith; first vice-chairman, Louise D. Acton; second vice-chairman, Isabel Black; third vice-chairman, Miss Walsh; secretary-treasurer, Dorothy Morgan; councillors, Evelyn Freeman, Bertha Griffin, Sister St. Donovan, Edith Moffatt, Margaret Hamilton, M. Stewart; section conveners: hospital and school of nursing, L. D. Acton; general nursing, Lillian Rogers; public health, Isabel Black.

District 8

"The nursing service should not be thrown a badly chewed bone in any system of health insurance such as now before us, or in any of the group medical schemes, one of which last year paid out $63,000 in medical fees, $21,000 in hospital fees, and $64 in nursing fees", declared Dr. Charlotte Whitton, C.B.E., at the general meeting of District 8 held in Ottawa. "As a citizen, the nurse has a direct responsibility to examine the whole range of reconstruction and so-called social security measures now being offered to the public, to judge their effectiveness, their practicability, our capacity to carry them, and the order of urgency in which they should be developed". A short refresher course for nurses is to be held early in the fall, Helen O'Meara, convener of the program, announced at the meeting. Plans for the course were discussed by the nurses present.

Dr. L. P. MacHaffie, school medical officer, gave an informal and practical talk on the health service as conducted by the public schools, at the well-attended meeting of the public health section. At the meeting of the general nursing section Dr. F. H. Cote gave a very informative and practical talk on newer trends in surgery. The hospital and school of nursing section were challenged to solve a few of the many nursing problems arising in the hospitals today. A lively discussion began after Mrs. A. Parsons presented an excellent paper which dealt with some of the problems. Mrs. Parsons was appointed to convene a committee which should make a further study and prepare a suitable report. The newer methods used in drainage were ably demonstrated by Miss G. Ferguson.

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District 10

The regular June meeting was held at McKellar General Hospital. The final arrangements for entertaining the graduating classes at a banquet were made. This is a joint dinner with McKellar Hospital Alumnae who are celebrating the fortieth anniversary of their training school. We were fortunate in having some of the delegates here on their way to the C.N.A. general meeting. Edna Moore, Department of Health, Toronto, was the guest speaker. Margaret Dulmage, recruitment convener, R.N.A.O., also spoke.

The Ontario Hospital plan was discussed and this plan is being left to the general nursing section to organize. A social hour was enjoyed and lunch was served by the McKellar Hospital staff.

QUEBEC

Montreal General Hospital:

The program of a recent meeting of the Alumnae Association consisted of nursing demonstrations. E. Denman showed the use and care of the tracheotomy, M. Shanno the latest in intravenous therapy, and L. Ellard, the set-up for a cut-down.

Miss Hornibrook, of the night staff, will shortly take up her duties at the Allen Memorial Psychiatry Hospital. Ann Scott formerly in the outdoor department and on Ward E, is to leave for Tranquille, B. C. K. Clifford and M. Brogan have temporarily accepted positions in the surgical outdoor department and Ward E.

Royal Victoria Hospital:

Gertrude Yeats, Dorothy Goodill and Winnifred MacLean, of the Royal Victoria staff, and Winnifred McLeod of the Alexandra Hospital, recently attended the C.N.A. general meeting in Winnipeg. Marguerite Webber and Edna Thompson have resigned from the staff. Recent visitors at the School of Nursing were Principal Matron Janet MacKay and Matron Rae Fellowes, R.C.N., Mrs. P. H. Perrin (Florence McCormack) and Mrs. J. P. Dewar (Marjorie Kendall).

McGill School for Graduate Nurses:

The annual meeting of the McGill School for Graduate Nurses was held recently with an attendance of 105. This took the form of a dinner given in honour of the graduating class of forty. Winnifred McCunn presided. The speaker of the evening was Kathleen W. Ellis who spoke of the contribution which the School is making across Canada, and paid tribute to members of the nursing profession serving both on the home front and overseas. Mrs. Stuart Townsend proposed the toast to the graduating class to which Inez Norem, the class president,

responded; E. Frances Upton proposed the toast to the School to which Miss Lindeburgh responded, giving a brief outline of the history and progress of the School, Marion Nash proposed the toast to absent members. Vera Graham, superintendent of nurses of the Homoeopathic Hospital, Montreal, was made an honorary member of the Alumnae Association, being proposed by Mary Mathewson, assistant director of the School. Reports were read from conveners of the various committees.

The officers for the coming year are as follows: president, Winnifred McCunn; vice-president, Electa MacLennan; secretary-treasurer, Rose Mary Tansey; conveners: Flora M. Shaw Memorial Fund, Mrs. L. H. Fisher; special finance committee, E. Frances Upton; program, Elizabeth Steele; representatives to: Local Council of Women, M. Brady, Mrs. H. Harding; *The Canadian Nurse*, Kathleen Stanton. Mary Mathewson has been appointed chairman of the committee in charge of plans for the silver anniversary celebration.

Lillian A. Athelstan (T. & S. 1941) has resigned from the teaching staff of the Homoeopathic Hospital. Recent visitors to the School included C. Lynch (T. & S., 1936), Mrs. J. P. Dewar (Marjorie Kendall, P.H.N., 1939), now residing in Troy, N. Y. Florence Stratton (P.H.N., 1943) is now on the staff of the Winnipeg General Hospital.

SASKATCHEWAN

Health Insurance was chosen as the topic of special study by the nurses in Saskatoon who have taken quite an active interest in the subject. Mrs. A. L. Caldwell, of the Senate of the University of Saskatchewan, gave a very interesting and constructive talk on health insurance from a layman's point of view. She indicated the value of a "working" health insurance scheme to the individual citizen and to the national health. Dr. Hazen a physician of Saskatoon, spoke at a later meeting stressing the medical side of health insurance, including nursing. The adjustments that might be required of medicine and nursing to fit into the plan of health insurance were considered. Both meetings were well attended by nurses from the three sections and the interest manifested in discussion periods following the adresses was very gratifying.

M.L.I.C. Nursing Service

Claire Lalancette (St. Jean de Dieu Hospital, Gamelin) was recently appointed to the Mount Royal nursing staff, Montreal.

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WANTED

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Miss Elizabeth Clark, Superintendent of Nurses, Royal Columbian Hospital, New Westminster, B.C.

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Two **Registered Nurses** are required **immediately** for **General Duty.** Eight-hour day; nurses home; $90 per month, with bonus for each year's continuous service. Apply to:

Magrath Municipal Hospital, Magrath, Alta.

WANTED

Applications are invited **immediately** for the position of **Science Instructor** for a School of Nursing, with 150 students, in a 335-bed hospital in **Alberta.**

Apply, stating qualifications and salary expected, in care of:

Box 20, The Canadian Nurse, 1411 Crescent St., Montreal, P. Q.

WANTED

Applications are invited for the following positions in a 146-bed hospital:
Classroom Instructor — Salary, $115 per month
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Complete maintenance is provided. State experience and qualifications in first letter to:
The Superintendent, Medicine Hat General Hospital, Medicine Hat, Alta.

WANTED

An **Instructor** is required for the **School of Nursing** of the **Aberdeen Hospital, New Glasgow.** The position is open on **August 15.**

Apply, stating qualifications, experience, and salary expected, to the:

Superintendent, Aberdeen Hospital, New Glasgow, N.S.

WANTED

The Vancouver General Hospital desires applications from Registered Nurses for General Duty. State in first letter date of graduation, experience, references, etc., and when services would be available. Eight-hour day and six-day week. **Salary:** $95 per month living out, plus $19.92 Cost of Living Bonus, plus Laundry. One and one-half days sick leave per month accumulative with pay. One month vacation each year with pay. Apply to:

Miss E. M. Palliser, Principal and Director of Nurses, Vancouver General Hospital, Vancouver, B.C.

WANTED

Registered Nurses, with Psychiatric training, are required for the **Allen Memorial Institute of Psychiatry, Royal Victoria Hospital, Montreal.**

Apply to **Miss F. Munroe, Superintendent of Nurses.**

WANTED

A **Residence Nurse** is required for the **University of Toronto School of Nursing.** The position is open on **September 1.** Apply, stating qualifications, to:

The Secretary, School of Nursing, University of Toronto, 7 Queen's Park, Toronto 5, Ont.

WANTED

Applications are invited for the position of **Classroom Instructor** in a 150-bed hospital. State experience, qualifications, and salary expected. Apply to:

Superintendent of Nurses, Sarnia General Hospital, Sarnia, Ont.

WANTED

Two qualified **Instructors** are required for a 100-bed hospital. The salary is $100 per month, plus full maintenance. At present, 38 students are enrolled in the School. The next Preliminary Class will be taken in September. Apply to the:

Superintendent of Nurses, Queen Victoria Hospital, Yorkton, Sask.

WANTED

Applications are invited for the position of **Night Supervisor** in a 100-bed hospital. Applicants with experience in Obstetrics preferred. The salary is $100 per month, plus full maintenance. Apply to the:

Superintendent of Nurses, Queen Victoria Hospital, Yorkton, Sask.

WANTED

A Hospital Superintendent is required for the **Glace Bay General Hospital** in **Nova Scotia.** There is a bed capacity of 212, including a tuberculous annex of 48 beds. There is also a training school with 60 students. State qualifications, age, religion, and salary expected. Applications will be received until July 15, 1944. Apply to:

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